The Modern Hospital

JULY 1958

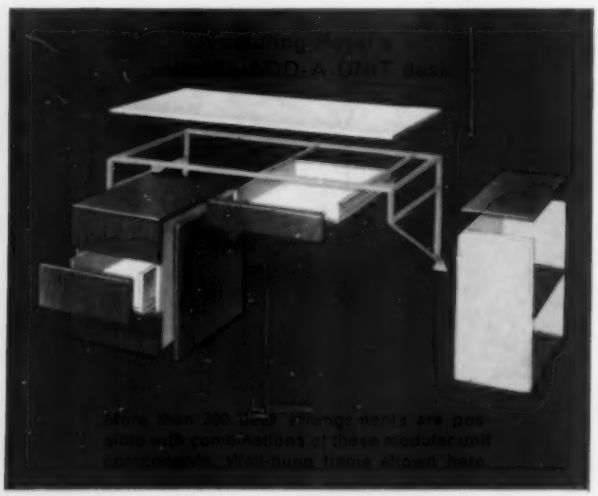
LOBBY OF ONE OF THE TWIN HOSPITALS OF PEOPLES HOSPITAL AUTHORITY, WAYNE, MICH. (Page 71)

Furniture available in Natural Birch, Frosted Walnut or Natural Walnut, with a wide variety of plastic tops.

An investment in lasting, maintenance-free beauty . . .

WOODRIDGE by Royal®

. . . the beauty of wood . . . strength of steel . . . versatility of replaceable panels and tops



Royal ADD-A-UNIT desks offer exceptional flexibility for individual needs. Beginning with just the basic desk, you can add 3-drawer storage units, center drawer, single or double bookcases as desired . . . or bookcases may be wall-hung separately.

There's a casual, home-like warmth . . . a friendly, comfortable charm in dormitories and staff quarters furnished with *Royal's* wonderfully practical and pleasingly modern WOODRIDGE. And, you're assured simplified maintenance and long-life economy because of WOODRIDGE's "Skyscraper" inner steel frame that permits instant, individual replacement of tops, panels or drawer fronts.

Tops are virtually indestructible . . . drawer interiors are all-metal with nylon center glides—never warp or stick. Long, Satin-Chrome legs provide ample off-the-floor clearance for easy housekeeping.

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Write for information and literature

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★ EASILY INSTALLED

★ ADEQUATE HEIGHT AND LENGTH

★ EASILY ACCESSIBLE

The new Hausted ¾ length rail is the most efficient answer to the growing demand that bed rails be permanently attached to every bed. MORE RIGID THAN MOST FULL LENGTH BED RAILS, this engineering achievement is unique in the added features it offers you:

1. It will easily adapt to 90% of today's hospital beds.
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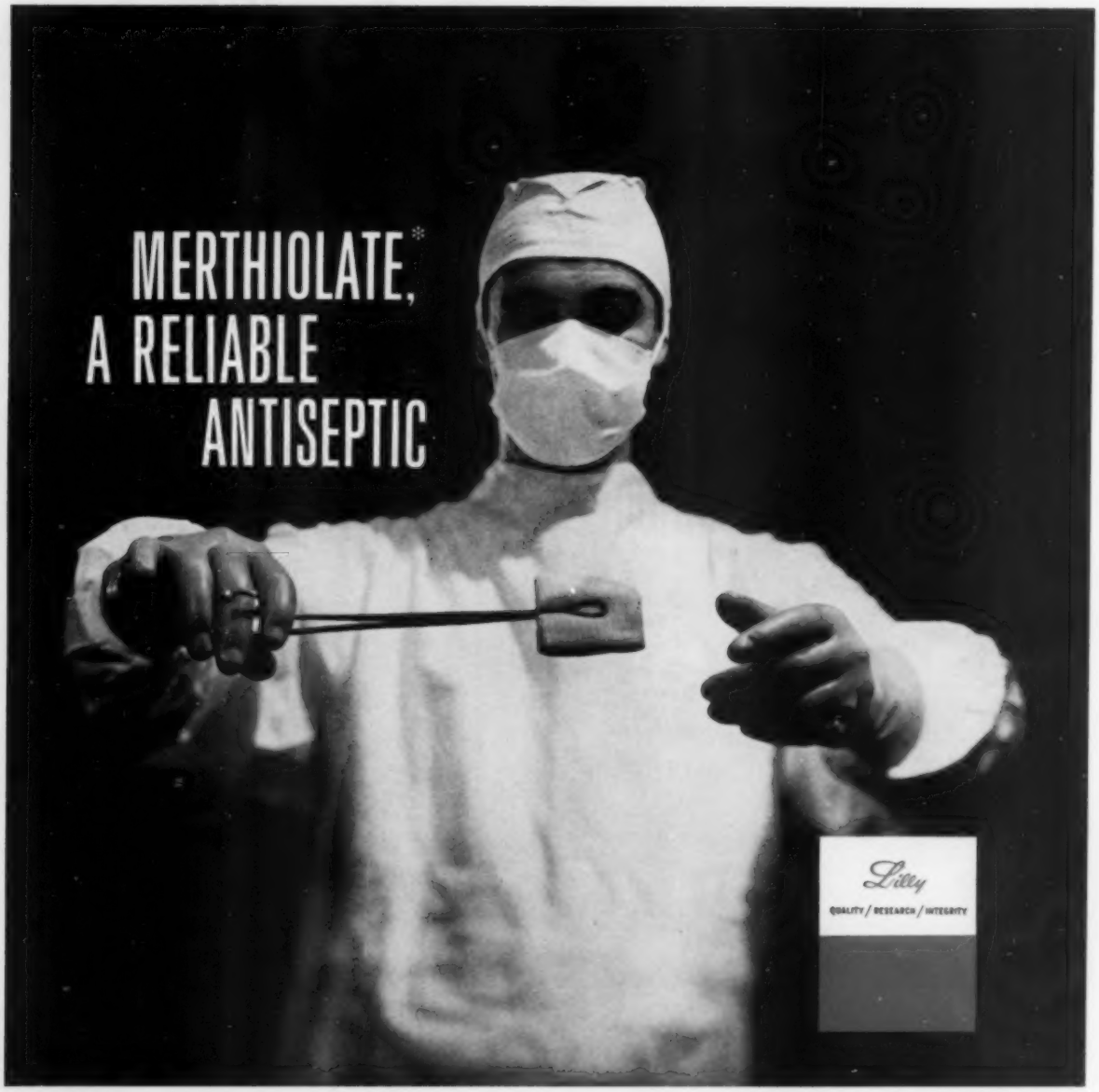

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The Modern Hospital

JULY 1958 VOLUME 91, NO. 1

Articles in this issue

Continued on next page ►

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The Modern Hospital

MEDICINE AND PHARMACY

FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

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ROVING REPORTER

Blocks Aid Army Students

Hospital administration students at Brooke Army Medical Center, Fort Sam Houston, Tex., aren't reverting to childhood when they assemble their building blocks these days—they're studying hospital planning.

Under the direction of Lt. Col. Seth H. Linthicum Jr., instructor in the department of administration at the army medical service school, officer students use building blocks to study both horizontal and vertical arrangements in a model hospital. The blocks, made of plastic, represent a 500 to 1000 bed military hospital, a replica of those now in use at Fort Knox, Ky.; Fort Bragg, N.C., and Lackland Air Force Base, San Antonio, Texas.

Previously, this type of study was done with blueprints alone, necessitating continuous handling of multiple, unwieldy sheets of paper.

When the plastic blocks are assembled, they show the entire multistory plan of the hospital, with all wings numbered and labeled for a side view from any angle. Dismantled, each floor of each wing can be used separately to determine the most efficient arrangement of necessary facilities.

U.S. Army Photograph

Hospital administration students at the Brooke Army Medical Service School check their blueprints against a plastic block model of a military hospital.

Students propose new arrangements to eliminate wasted motion or space in planning, based on the plans that have been drawn to scale on each floor of the plastic model. Individual scale drawings of modifications can be checked against the hospital model for feasibility of the rearranged plans.

Although an architect does the actual preparation of plans for new medical structures, the hospital commander and administrator must present requirements, based on medical considerations, for the architect to incorporate in his drawings. The administrator also must be able to make recommendations when an existing structure is to be remodeled into a hospital in an emergency, officials of the school point out.

Building Public Relations

How to tell the patients, public and employes about what's going on during a building program is a concern of many hospitals, as construction of additions and remodeling goes on apace.

At Little Company of Mary Hospital, located in the midst of a residential district in Evergreen Park, Ill., a leaflet was prepared to tell the patients and the neighbors all about a new service building.

The cover is a cartoon of construction workers at the building site, admonishing each other to "fall quietly" and "use *soft* water to mix the concrete."

Inside, the text reads: ". . . The $4,200,000 addition to the hospital which we began means that we plan

Another Resistant Staph
Weapon from Huntington...

HEXA-GERM

Prevents Staphylococcal Skin Infection

in the Newborn Nursery

From an Ohio State University paper,* "... in our experience and that of others, hexachlorophene baths constitute a safe, relatively convenient and effective method of preventing *staphylococcal* skin infection in the new born nursery."

The departments of Pediatrics and Bacteriology of the Ohio State University in a study of an epidemic among infants and nursing mothers reported they used, "... a liquid cleansing detergent containing 3% hexachlorophene, (Hexa-Germ was one of two products used) and employing a brush and orange stick."

The handwashing procedure was evaluated and a number of tests failed to show any *staph*, "... on the hands and forearms of nurses who had recently washed with detergent containing hexachlorophene. Furthermore, after a nurse wore rubber gloves for an hour after having scrubbed, cultures taken from the inside of the gloves showed no growth."

Hexa-Germ is effective against all strains of *staphylococcus aureus*, including those that could develop into pneumonia and osteomyelitis. It is a white, viscous liquid antiseptic detergent cream, containing 3% hexachlorophene, blended with lanolin and petrolatum to help prevent skin drying.

Hexa-Germ is just one of the many Huntington Antiseptic products that can help you keep infections in your hospital at safe levels.

*STAPHYLOCCAL INFECTIONS IN NEWBORN INFANTS. I. STUDY OF AN EPIDEMIC AMONG INFANTS AND NURSING MOTHERS. By Thomas E. Shaffer, M.D., Jack N. Baldwin, Ph.D., Melvin S. Rheins, Ph.D., and Robert F. Sylvester, Jr., M.D., Departments of Pediatrics and Bacteriology, Ohio State University (Pediatrics, Vol. 18, No. 5, November 1956)

See the Man Behind the Drum, your Huntington representative, for full details.

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to be your friend and neighbor for many, many years. We feel that we can better serve the communities surrounding us by providing proper space and equipment for all important service departments and to resituate them in the most efficient manner conceivable.

"Join us, won't you, as sidewalk superintendents? Many of you can watch from your windows. We hope it will be a good show, having a modern building going up right outside your window. It will take us awhile, but we hope that by June 1959 we will be able to invite you over to visit our brand new addition—this time as a visitor and not as a patient."

Another page of the leaflet tells what the hospital's development program will accomplish and features a rendering of the addition. Those who are interested in more details of the expansion program are invited to call the hospital for another brochure.

The leaflet is placed on each new patient's tray by the dietary department, and copies have been distributed to homeowners in the immediate vicinity of the hospital, Emilia S. Todd, administrator, reported.

At Bethesda Hospital in Cincinnati, a lobby display was arranged to answer the questions of visitors, medical staff, and employes about the progress of a new building. On a near-by bulletin board are placed samples of materials to be used in the interior of the new building. These will be changed each month.

Besides the main theme—adding a new building and beds in a critical area—the hospital is trying to show the public how its money, contributed in a recent fund drive, is being spent, and ask for more at the same time, Administrator Lawrence Brett stated.

Cover of the leaflet distributed by the Little Company of Mary Hospital.

Floor plans of the new building going up at Bethesda Hospital, Cincinnati, are on display in the hospital's lobby to let visitors and employes know what progress is being made.

NEW MONSANTO REPORT ON SANTOPHEN 1 DEFINES . . .

THE STAPH* MENACE AND HOW TO AVOID IT

(Santophen 1 is Monsanto's tradename for 2-benzyl-4-chlorophenol)

To help prevent the possible outbreak of staph problems, U. S. hospitals can rely on new disinfectants, germicides and cleansing agents formulated with Monsanto's chlorinated-o-substituted-phenol Santophen 1, the most potent phenol germicide available against staphylococcus aureus.

Santophen 1 combats staph. With a phenol coefficient of 200, Santophen 1 is highly toxic to both gram-positive and gram-negative organisms and fungi. (Ordinary pine oil germicides have absolutely no killing power against staph or other gram-positive organisms.)

Santophen 1 is safe. Virtually odor-free, Santophen 1 has a low order of toxicity to humans and, with the absence of skin irritability, it offers the ideal all-purpose germicide for hospital use. Maintain first-rate aseptic methods with Santophen 1 formulations . . . before a staph problem develops.

Write Monsanto for suppliers in your area. You'll be interested in Monsanto's new report, "Santophen 1 for Control of Staphylococcus Infections in Hospitals." This report traces the U. S. staph problem and the proved performance of Santophen 1 in combating various strains of staphylococcus aureus that are resistant to one antibiotic after another. Just mail coupon below for complete information.

MONSANTO REPORT, "SANTOPHEN 1 FOR CONTROL OF STAPHYLOCOCCUS," COVERS...

- **Why the need for good general disinfectant is acute**
- **Where to check for staph build-up**
- **General hospital disinfectants**
- **Hospital floor and wall cleaners**
- **Surgical instrument cleaners**
- **Aerosol sprays for hospital rooms**
- **Hospital-tested formulations for washing blankets**
- **Germicides for washes**
- **General information on available formulations**
- **Why Santophen 1 formulations are best for control of in-hospital infections.**

(Staph: Micrococcus pyogenes var. aureus, sometimes referred to as staphylococcus aureus.)

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Please send: ☐ Names of suppliers formulating with Santophen 1.
☐ Report No. CS-8, "Santophen 1 for Control of Staphylococcus."

Name .....

Hospital .....

Address .....

City ..... *Zone* ..... *State* .....

READER OPINION

Nursing Unit Too Big

Sirs:

The hospital nursing consultants in this section asked me to write you in reference to a comment made in the March 1958 issue of The Modern Hospital. On page 69 the following statement appears:

"The maximum, and the best, nursing unit is 60 beds. This size enables the hospital to provide the professional nurse economically with the services and nonprofessional assistance she needs so that she can devote herself entirely to nursing."

The nurses would like clarification as to what is meant by a nursing unit. Is it a section in the hospital for the care of certain types of patients, and is the unit under the direction of one head nurse?

The nurses feel this is too large a unit for one head nurse to supervise. They discussed this with the group of nursing service administrators in hospitals in the Seattle area, and, in the course of the discussion, the following comments were made:

1. Turnover is so great in hospitals today that it is difficult to keep up to date on patients.

2. The larger the unit, the more doctors there are to assist, know their routines, and so on.

3. Medications and treatments have become increasingly complex.

4. One hospital has a nursing unit with 34 to 36 patients. It has been necessary to add an assistant head nurse to the staff in order to do an adequate job of supervision.

5. Another hospital has nursing units of 45 beds, and this situation was described as "impossible."

6. A good size for nursing units is 24 to 28 beds. In this unit the head nurse can know her patients, and supervise their care, and also know her staff members and supervise their work.

If the team plan is used, 20 beds are ideal, so 10 patients can be assigned to each captain to supervise.

We realize from statements made by the editorial staff that some of the concepts of hospital administration that were mentioned are not universally accepted, but they did represent the considered opinion of thinking men and women on the subject of additions to hospitals.

Philip A. Austin
Head
Hospital and Nursing Home Section
The State of Washington
Department of Health
Seattle

Ph.D. Spells Doctor

Sirs:

I received my April issue of The Modern Hospital with its article entitled "First They Expanded the Nursing School—Then Came Students," which describes our nurse recruitment and selection program here at St. John's Episcopal Hospital.

I find that in the published article no mention is made of my degree of Doctor of Philosophy in Psychology and I am referred to as "Mr." Haggerty despite my understanding that the original manuscript referred to the Ph.D. and the title "Dr." I had noticed the same condition last year when Mr. Melvin H. Dunn had published in your journal an announcement of my appointment to the hospital and also in articles concerning other holders of academic doctorates.

It thus appears that it is your editorial policy to ignore recognition of doctorates unless they are in the field of medicine. I am certain it is not necessary to inform you that the title "Doctor" is not a synonym for physician, especially in the minds of the professionals who read your journal. If you do fear that the use of the title Doctor might lead to confusion then at least indicate the proper degree and not ignore it altogether.

I would like a personal explanation of this policy and also feel that an apology is due to the many scientific disciplines such as psychology, dentistry, chemistry, etc., where doctorates other than the M.D. are earned. Prejudice such as this has already hindered relations between medicine and its cooperating sciences.

My present feeling would preclude my submitting an article to a journal which refuses to grant full professional and academic recognition of doctoral degrees other than that minority awarded to physicians.

Arthur D. Haggerty, Ph.D.

St. John's Episcopal Hospital
Brooklyn, N.Y.

We are glad to apologize to Dr. Haggerty herewith, but, short of buying billboard space, we're not sure how to go about apologizing to "the many scientific disciplines such as psychology, dentistry, chemistry, etc."

Since Dr. Haggerty has already decided we have a prejudice, however, we don't feel inclined to offer the requested explanation. One thing about doctors of medicine: They usually examine the evidence before passing judgment.—Ed.

Hot Headlines Dramatize Need for Basic Public Education

By Gordon Davis

Gordon Davis

WELL, how do you like being in politics? I mean really in—in well beyond the point of no return? We may as well face it: Our hospitals are being virtually evicted from the state of pleasurable total absorption in patient care. They have emerged into the field of fast and furious competition for public favor, and they are up against some real pros in this contest.

The recent hearings on Blue Cross subscriber rates in the East are the latest token of this somewhat reluctant migration, for, as the hearings so spectacularly demonstrated, it is impossible to divorce Blue Cross rates from hospital costs and practices.

Sometimes it takes hot headlines to underscore situations that have been long in development. In this case, the Blue Cross hearings brought to the state level a new kind or degree of hospital involvement with political considerations.

By no means should this be construed as using the term "politics" in a derogatory sense. Our government representatives generally do what they are supposed to do: base their decisions on their best judgment of the delicate balance between public interest and popular desires.

The two are not always compatible. Like dieting, long-range public interest often requires acceptance of actions that are distinctly unpalatable. Only when the validity of the harder course has been clearly demonstrated does it draw the popular support that assures its adoption.

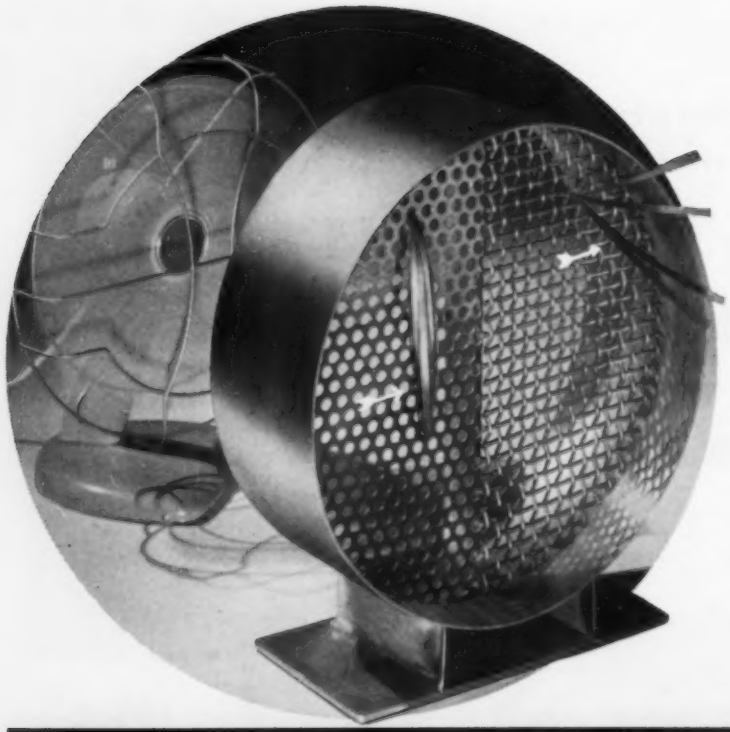
But such is the process of democracy. In the last analysis, we must hold to the faith that, in the great majority of cases, there are only two possible causes of what we may consider unfavorable actions by the people or their representatives. Either we were wrong in the first place, or we have not sufficently demonstrated the rightness of our position.

Which are we to assume is at the roots of the rising controversy over hospital costs? Are these costs too high, or have we failed in the important task of developing public understanding of them?

Under current conditions I can see no justification whatever for deluding the people into believing that hospital costs can be reduced —or even that the rise of costs can be halted—without comparable reduction of hospital services. All other influences—presumed "misuse" of hospitals, alleged "abuse" of prepayment benefits, and the like—are straws in the tidal wave of rising wage levels and the expansion of essential hospital services.

If this premise is correct, only failure to do the right kind of job of public education can be blamed for the popular delusion that there is a magic solution to the costs problem. Such delusions invariably lead to restrictions, legislation and outside controls if they are not corrected, and we cannot look on recent developments as pointing in any other direction.

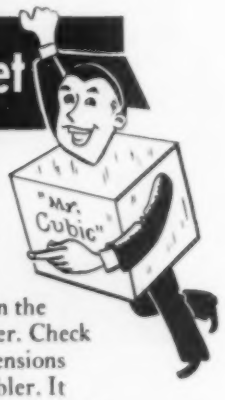
Being "in politics" is, in its best sense, an adventure in democracy. Essentially it means sharing with the people the responsibility for the continued progress of their own institutions. To put it in plain and impolitic words, there hasn't been enough of this sharing in our field, and the price will be heavy if the oversight is not swiftly remedied.



'It figures . . . greater flow of air through the laundry tumbler results in faster, more efficient drying and conditioning. The new Drynamic Challenge Tumbler receives 50% more air through the sturdy woven wire basket than perforated sheet basket material used by most other machines. The Comparison test, photographed at left, shows how the unrestricted flow of air on the "Drynamic" side (woven wire) lets the *test ribbons* fly in the breeze, while the ribbons in front of the perforated sheet barely flutter.

Proven *on the job* too. At 60% retention, a 200 lb. (dry wt.) load of bath towels will fully dry in just 16 minutes . . . on other fabrics the Drynamic removes a gallon of water per minute.

Compare The "Air Flow" Through The Tumbler Basket



COMPARE THE CUBIC VOLUME TOO

Compare the cubic volume of the tumbler basket . . . it makes a tremendous difference in the efficiency of your tumbler. Check the tumbler basket dimensions before YOU buy a tumbler. It takes one cubic foot of basket area for every 2 pounds of material. The Drynamic has 95 cu. ft. of basket area. Competitive machines have only 69 or 72 ft., yet "rate themselves" at 200 lb. capacity.

Remember, the smaller the "cubics" (cubic feet of basket area), the longer the drying time. Compare the Drynamic's 95 cu. ft. basket with other machines claiming a 200# dry weight capacity.

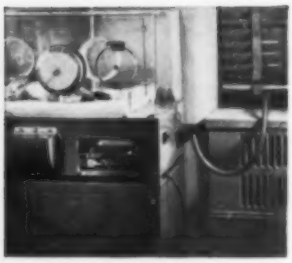
Get the facts on the

Drynamic
CHALLENGE TUMBLER
IT'S THE FASTEST

CHALLENGE MANUFACTURING CO.
7400 E. BANDINI BLVD. • LOS ANGELES 22 • RAymond 3-1301

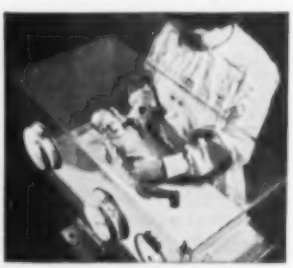
Distributed Exclusively by: THE AMERICAN LAUNDRY MACHINERY COMPANY

Isolation with accessibility: The infant is protected from nursery air by a spacious, transparent hood. Four iris-diaphragm ports and one hinged port provide complete accessibility.



Individually air-conditioned, the ISOLETTE® continually draws in fresh air from outside the hospital, protecting the infant from air-borne nursery pathogens, even when iris ports are open.

Positive humidity control with a simple valve. Constant, controlled recirculation of moist, fresh air maintains humidity at desired optimal level, as high as 85% to 100% —without need for additional heat.



Precise temperature control within a tolerance of 1°F., with device for cooling as well as heating, and **automatic alarm** should outside factors cause overheating.

the **Isolette®** infant incubator offers

Greater Protection for the Premature

The ISOLETTE, only "completely air-conditioned" infant incubator described and illustrated in the new 2nd edition of *"Premature Infants,"* may serve also as "an isolation unit in addition to maintaining optimal environmental conditions, and is particularly useful in caring for the smallest infants." Dunham, E. C.: *Premature Infants,* 2nd Ed., Hoeber-Harper, New York, 1955.

Moreover, "The ISOLETTE® is probably the greatest single aid available in the surgical care of the tiny infant . . . it provides well-regulated warmth and humidity and economical oxygen concentrations in a convenient working area for nurse and doctor . . . unsurpassed visibility . . . and convenience of handling . . . The isolation of the patient from his neighbors and from the contaminated or ailing doctor or nurse is an additional safeguard. Intravenous cutdowns, weighings, spinal taps and other procedures are all possible within its protective shell." Lynn, H. B.: POSTGRAD. MED., 22:493, Nov. 1957.

The Isolette®

Fresh-air-flow infant incubator by **AIR-SHIELDS, INC.**

Phone collect, OSborne 5-5200, Hatboro, Pa., and order with 30-day return privilege.
IN CANADA: AIR SHIELDS (CANADA) LTD., 8 Ripley Avenue, Toronto 3, Ont. (Roger 6-5444)

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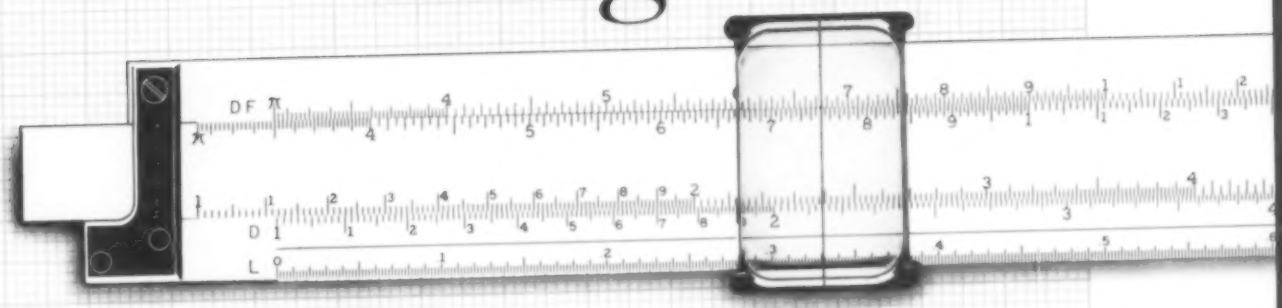
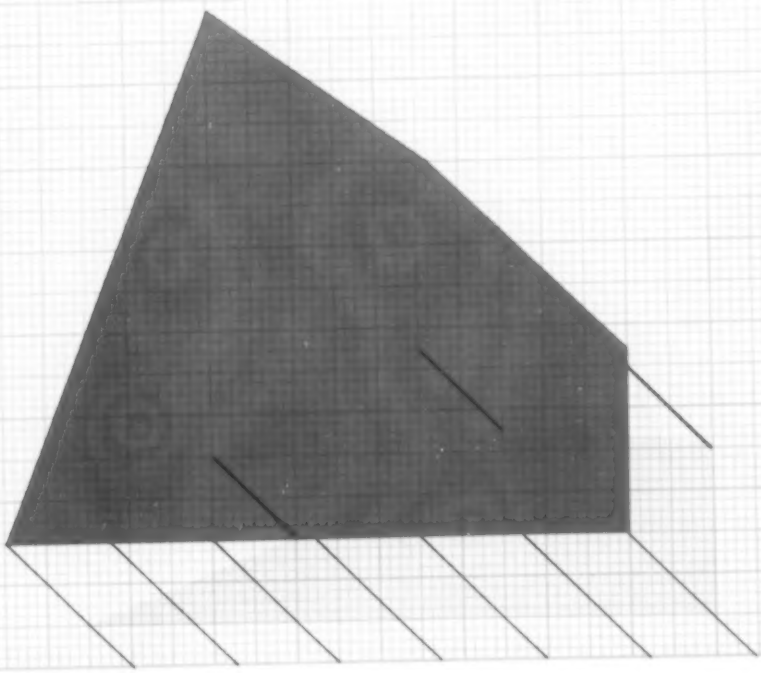


for superiority



new

PRONOUNCED TAY-O

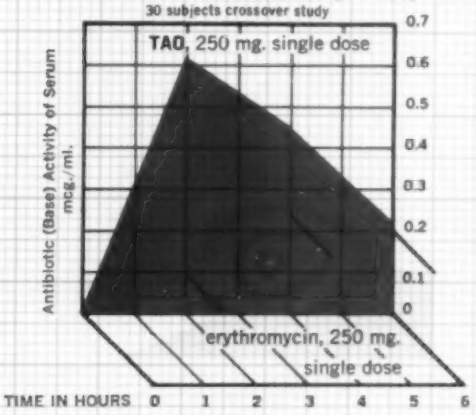
Tao*

(brand of triacetyloleandomycin with gluCOSAmine)

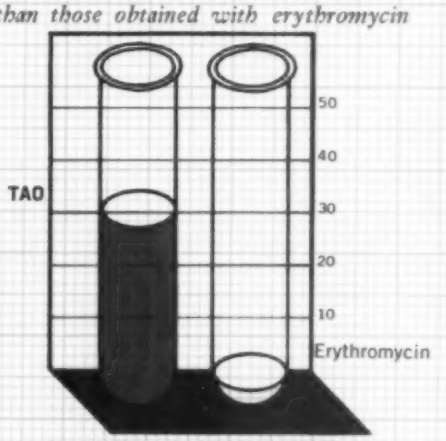
Capsules / Oral Suspension

designed for superior control of common infections

Average Tao *blood levels are two to six times those obtained with erythromycin*



Tao *gives urinary concentrations greater than those obtained with erythromycin*



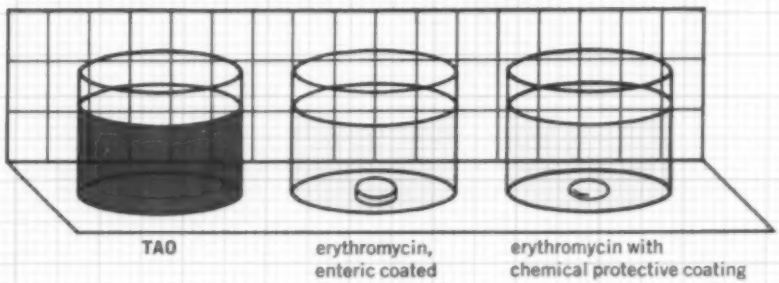
Per cent of the orally administered antibiotic activity detected in a composite 8-hour urine sample following ingestion of a single 250 mg. dose.

Tao *is effective against 9 out of 10*

CLINICAL DIAGNOSES	Respiratory Infections
adults	105
	23 Acute pharyngitis
	15 Acute tonsillitis
	11 Lobar pneumonia
	9 Bronchial pneumonia
	9 Acute bronchitis
	38 Other respiratory
children	142
	48 Throat infections
	28 Acute pharyngitis
	24 Acute tonsillitis
	18 Otitis media
	24 Other respiratory

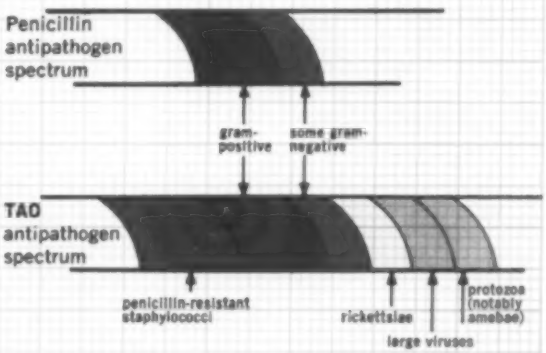
*TRADEMARK

TAO is therapeutically stable in gastric acid; does not require protective coating

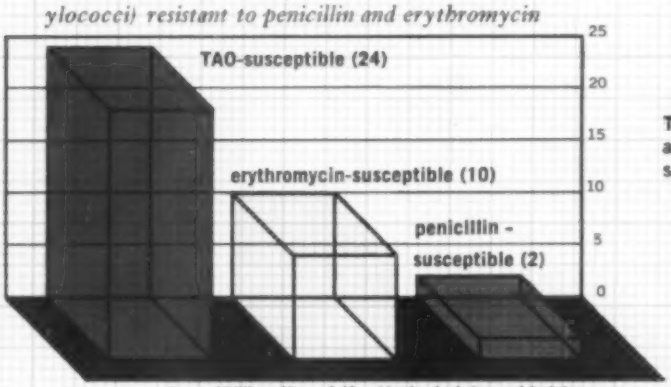


In minutes, TAO is available for absorption in the stomach.

TAO has a greater spectrum of efficacy than penicillin, including penicillin-resistant staphylococci



The antimicrobial spectrum of TAO encompasses even strains of common pathogens (notably staphylococci) resistant to penicillin and erythromycin



Susceptibility pattern of 40 epidemic staphylococcal isolates from Houston, Galveston and New York City, April, 1958; susceptibility determined as response to 3.12 mcg. or units per ml. or less, in standard broth dilution procedure.

common infections: Summary analysis of 385 case reports

Skin and Soft Tissue Infections

75

18 Cellulitis
17 Furunculosis
40 Other skin and soft tissue

16

10 Furunculosis
6 Other skin and soft tissue

Urinary Tract Infections

32

10 Cystitis
10 Gonorrhea
12 Other urinary tract

Miscellaneous

8

Septicemia
Diabetic gangrene
Purulent arthritis
Hiatal hernia
Gastroenteritis

7

Septicemia
Gastroenteritis
Infectious diarrhea
Osteomyelitis

CLINICAL RESULTS	adults	children	all Staph. infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (7%)	3 (3%)

Types of infecting organisms:

The majority of identified etiologic microorganisms were Staph. aureus (32 in adults and 19 in children), and Staph. albus (13 in adults and 7 in children). TAO has its greatest usefulness against the common infections caused by organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217) (nausea, diarrhea, flatus)	Gastrointestinal—0.6% (1 out of 167) (diarrhea)

There was complete freedom from adverse reactions in 94.5% of all patients.

Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

℞

new Tao capsules or oral suspension

when you need...

- highest stability in gastric acid
- rapid, high and sustained absorption with blood levels higher than those of any other agent in the erythromycin group
- effectiveness against strains resistant to other antibiotics, including the penicillins and erythromycin
- a broader spectrum than that of the penicillins, without risk of penicillin sensitization
- uniquely high urinary concentrations
- minimal interference with normal gastrointestinal flora
- outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective.

Since TAO is therapeutically stable in gastric acid, it need not be administered with meals.

Supplied: TAO Capsules—250 mg. and 125 mg.; bottles of 60. TAO for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

Write for comprehensive brochure on TAO.

J. B. Roerig and Company / *Division, Chas. Pfizer & Co., Inc.*
800 Second Avenue, New York 17, N. Y.


ANOTHER USEABLE
ACHIEVEMENT BY
Castle

ANOTHER USEABLE ACHIEVEMENT

Castle Straightline Sterilizers

UP TO 50% MORE CHAMBER CAPACITY

We want you to get to know this new Castle Straightline Sterilizer. Physicaliy it's the most attractive autoclave we've ever designed. But it's not just better looking. It's a *useable* achievement! Straightline weds the exclusive advantages of our well known cylindrical autoclave with a new, roomy rectangular chamber.

What This Means To You . . .

In the Dietary Department: The Castle Straightline Autoclave provides added capacity for glass containers. It will process as many as 192 formula bottles in a single load! Two of these Autoclaves functioning side by side will process the same load as the largest rectangular infant formula unit made.

In the Emergency Department: A Straightline Autoclave in your department will guarantee that rapid and sometimes critically needed service while doubling your output.

In the Central Supply Room: The Straightline Autoclave is the economical answer to those small hurry-up jobs.

In the Operating Room: Instruments may be sterilized in minutes in a Castle Hi-Speed Straightline Sterilizer. And sterilizer output is increased a full 50% over cylindrical types.

Write for descriptive folder.

WILMOT CASTLE COMPANY
BOX 629 • ROCHESTER, N. Y.

1883
1958

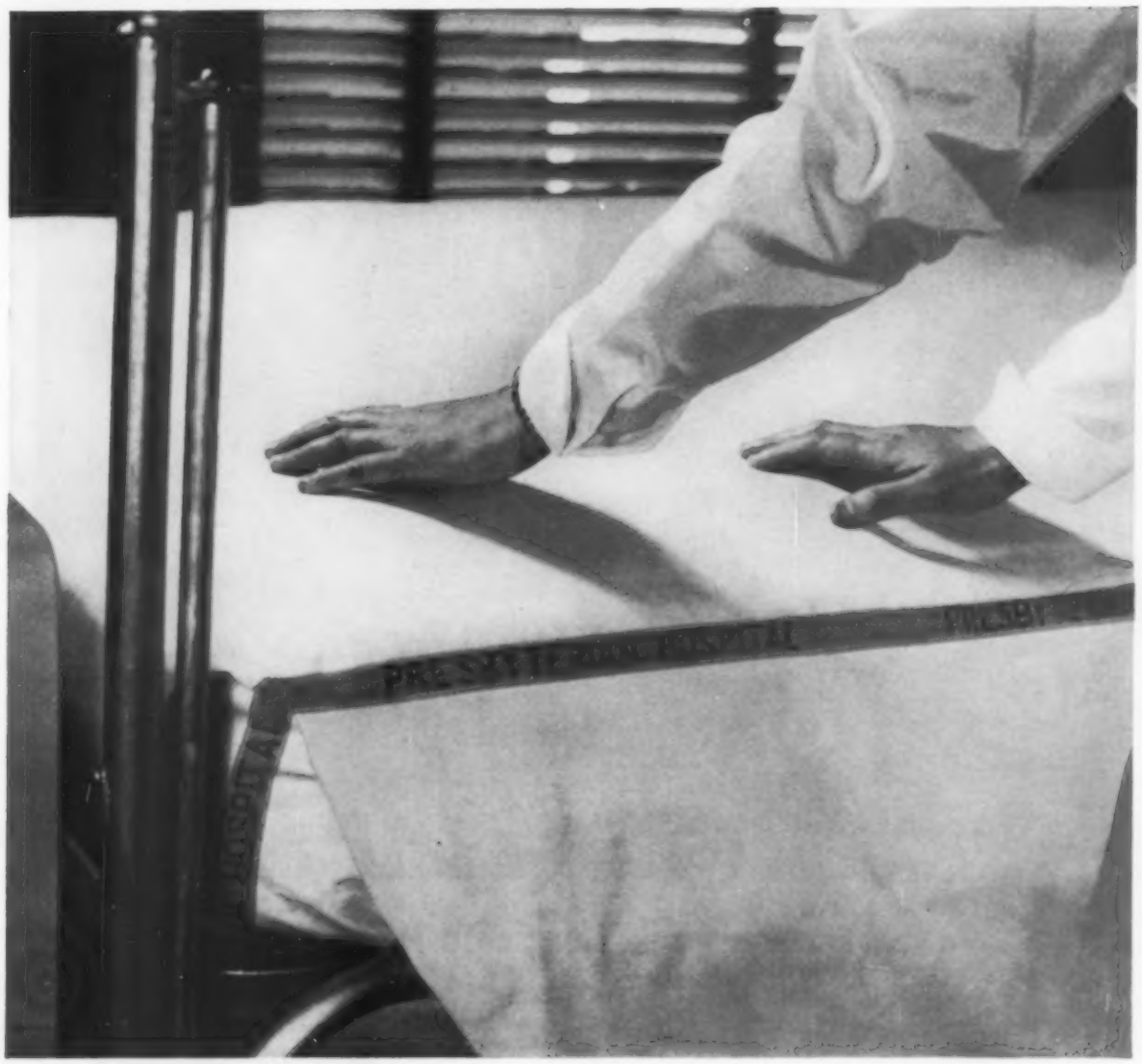
Diamond Jubilee Anniversary

Castle

PIONEERS IN SURGICAL EQUIPMENT SINCE 1883

Printed in U.S.A.

Pequot® name-woven bed linen for quick, neat, permanent identification



Everything about these Pequot name-woven sheets and cases makes sense. There's no identification more permanent and positive than your name woven in color on a matching stripe. It's far neater—eliminates hand marking. It discourages pilferage. The choice of 4 different color stripes (blue, green, gold, and tan) makes it more useful in identifying your institution, the section or wing, and the size of the sheet. Lastly, the stripes—exactly 14″ in from each selvage—are very handy guide lines for quicker bed-making. Pequot sheets and cases are guaranteed to exceed government specifications. Their wearability has set the standard for institutional linens since 1831.

For the name of suppliers of Pequot Name-Woven Sheets and Pillow Cases, available in Plus-Service Muslin or Combed Percale, write to Hospital Service Department, Indian Head Mills, Inc., 111 West 40th Street, New York, N. Y.

PEQUOT DIVISION

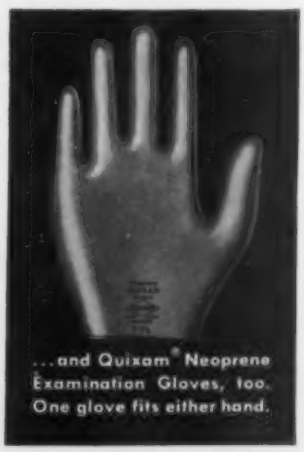
Indian Head Mills, Inc. Also manufacturers of Indian Head® brand fabrics.

Rx: For Persons Allergic To Natural Rubber... ROLLPRUF® Neoprene Surgical Gloves

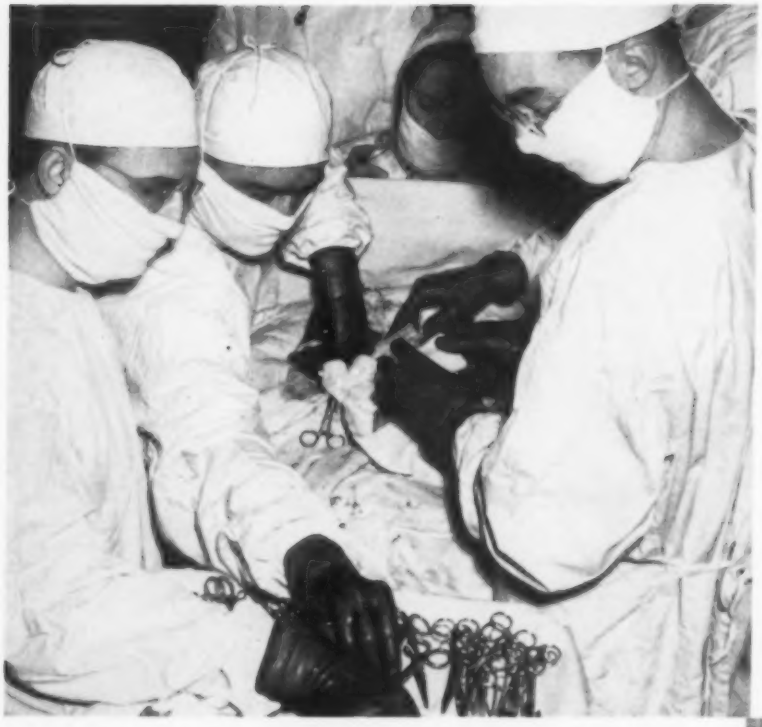
Hospital-green, soft-textured, non-allergenic neoprene. Flat-banded cuff won't roll down. Multi-size markings for easy sorting.

the PIONEER Rubber Company
350 Tiffin Road, Willard, Ohio

Pioneers in Surgical Hand Protection for 40 Years



...and Quixam® Neoprene Examination Gloves, too. One glove fits either hand.



one tiny spark could bring DISASTER!...

APPLETON explosion-proof equipment gives you positive, up-to-date protection against explosion and fire hazards!

(U.L. approved for all hazardous areas in Class I, Groups C and D)

The specialized talent of APPLETON'S engineering department backed by practical experience gained in years of analyzing hospital explosion-proof requirements make APPLETON explosion-proof equipment your finest buy . . . your safest buy. There has grown around the APPLETON name, a considerable reputation in the hospital and architectural field for installations which require the barest minimum of maintenance. This factor is extremely important in that it assures you a lifetime of trouble-free operation and enables you to expand your initial purchasing estimates to include *everything you need*. Consult your electrical contractor for a safety check on your explosion-proof needs, and remember to specify APPLETON . . . the quality name in explosion-proof equipment.

X-ray film illuminators for hazardous or non-hazardous locations.

Receptacle with plug.

Two-gang Pilot Lights. Available in single gang and in combination with switch.

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Portable Current Tap with feed-in plug.

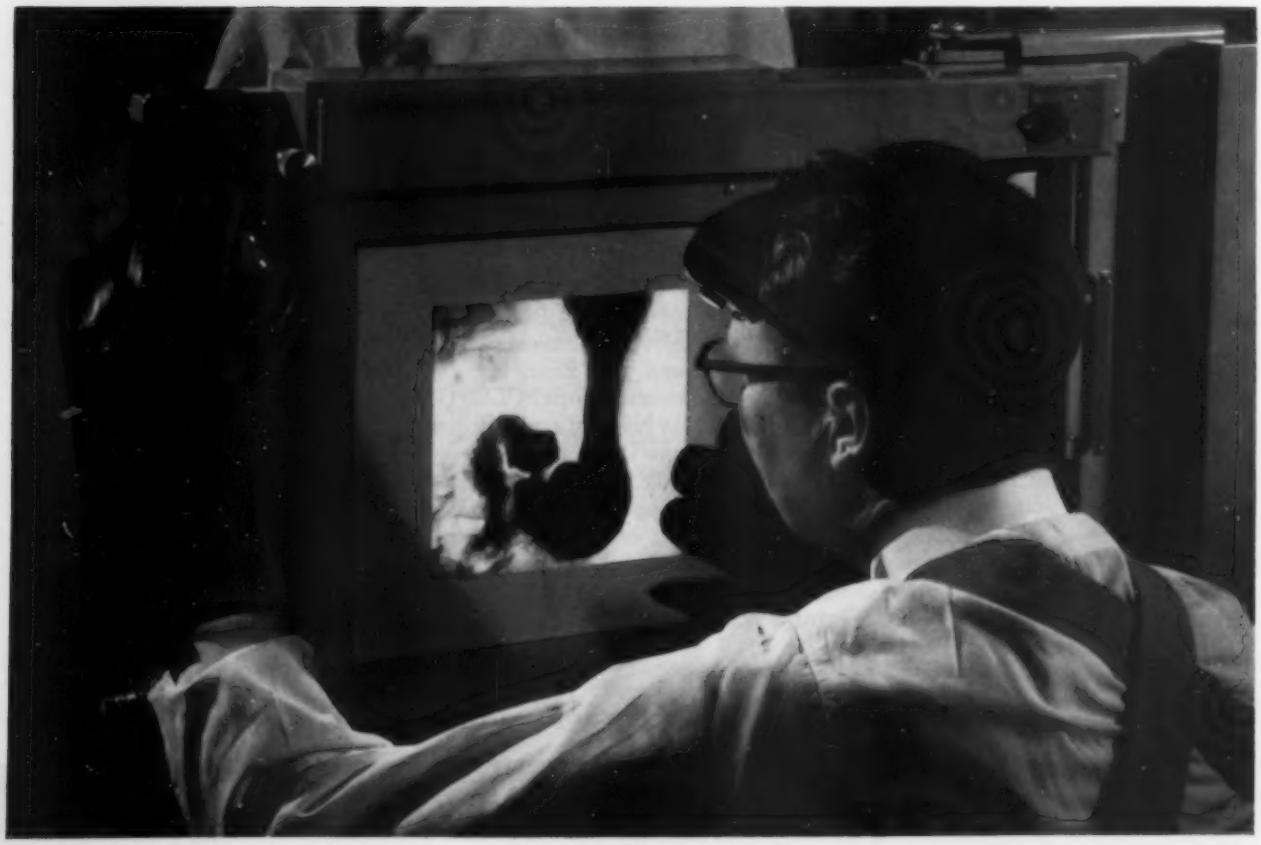
Sold Through Franchised Distributors Only

APPLETON ELECTRIC COMPANY *1743 Wellington Ave. · Chicago 13, Ill.*

Just what did you have in mind, Dr. Roentgen

Was it a diagnostic x-ray unit? Did it include automatic phototimed spot-film unit? Would design be function-mated to the needs of radiologists, whose specialty was born of your discovery?

If this is what you envisioned, Dr. Roentgen, you must have been looking forward to... THE GENERAL ELECTRIC REGENT

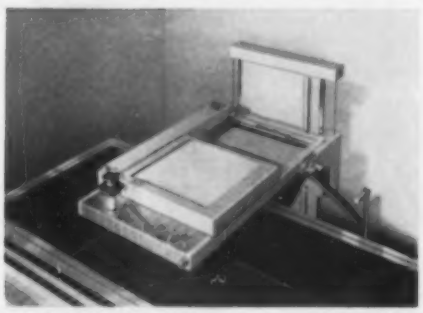


The General Electric Regent more than lives up to the promise of Roentgen's discovery and all the developments that followed. But we'd prefer that it be judged in terms of *what the doctor ordered* — and we're speaking of you, the modern radiologist, rather than Roentgen, the 19th Century physicist. Radiologist-guided design tells the story of this all-round diagnostic x-ray unit.

For example: Regent's automatic spot-film unit features low mass — it's a delight to maneuver. 45° Trendelenburg offers preferred depth of angulation. Smooth hydraulic drive provides variable angulation speed. Now, with *doubled* motor power, you get instant response under all loads, completely *free* of annoying vibration.

And Regent has true "island-table" design — obstruction-free all around. Overhead tube hanger does away with floor rails, opens area to foot traffic and hospital carts.

Meet the Regent personally! Your G-E x-ray representative will gladly introduce you to one of the many already installed in your area. Or write X-Ray Dept., General Electric Company, Milwaukee 1, Wis., for Pub. H-71.



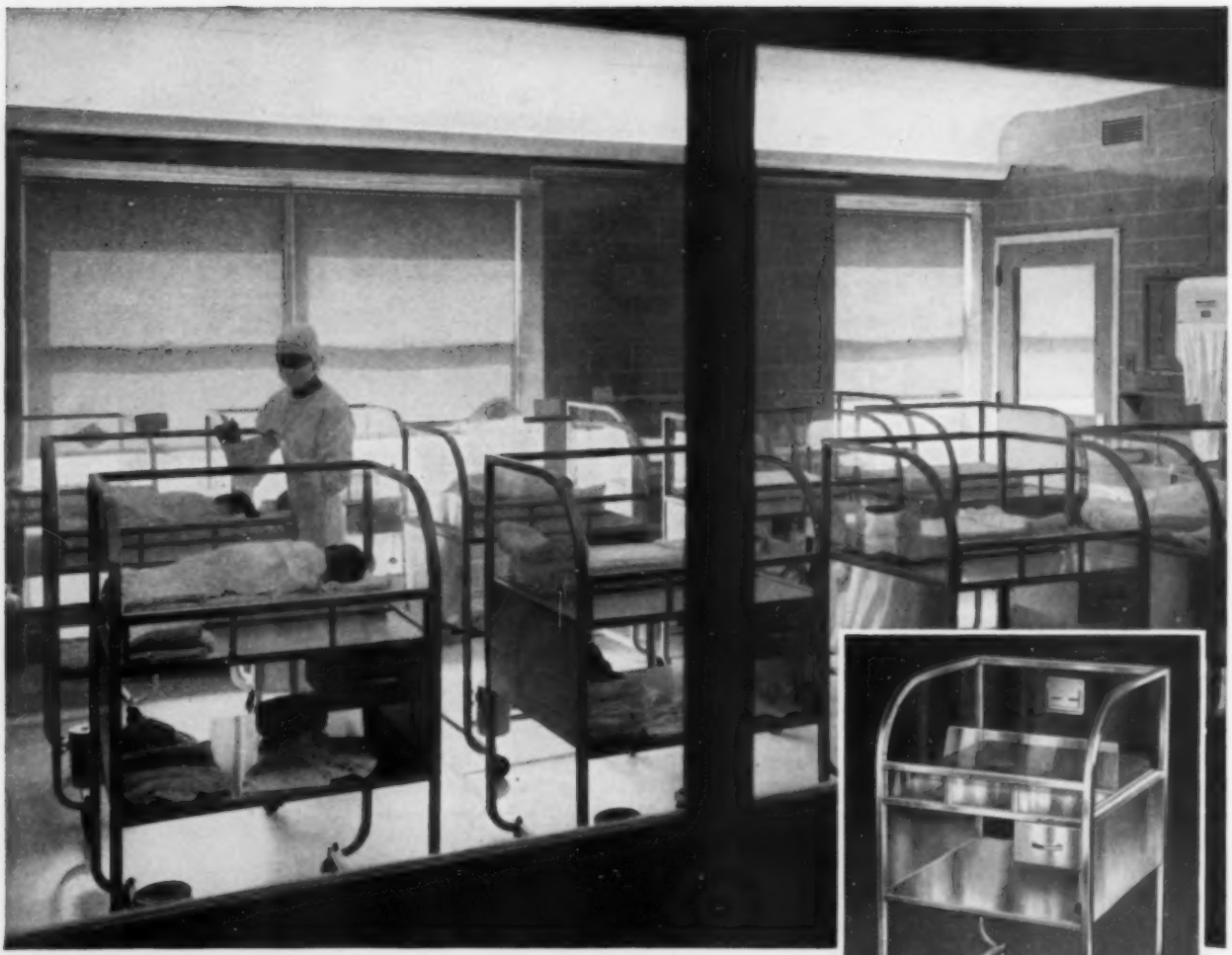
How's this for automated fluoroscopy?

General Electric spot-film unit provides photo-timed exposures . . . automatic cassette transfer and return, plus sequence selector . . . elective use of 10x12 and 8x10 cassettes . . . toggle-switch control of table drive. *Automatic shutter limiter* keeps x-ray field always safely within screen area. Many other features we'd be pleased to demonstrate.

Special terms available during OPERATION upturn GENERAL ELECTRIC

Progress Is Our Most Important Product

GENERAL ELECTRIC



The Magee Bassinet shown above embodies every facility for individual care, yet the entire unit requires less than six square feet of floor space. Ideal for "in-nursery" and "rooming in" care—a complete cubicalized nursery in itself. Model P9913.

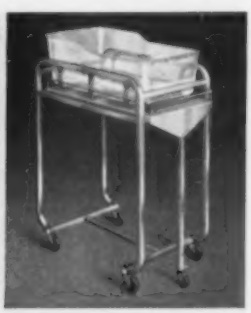
P9904—Cabinet Model
Sliding doors, both sides

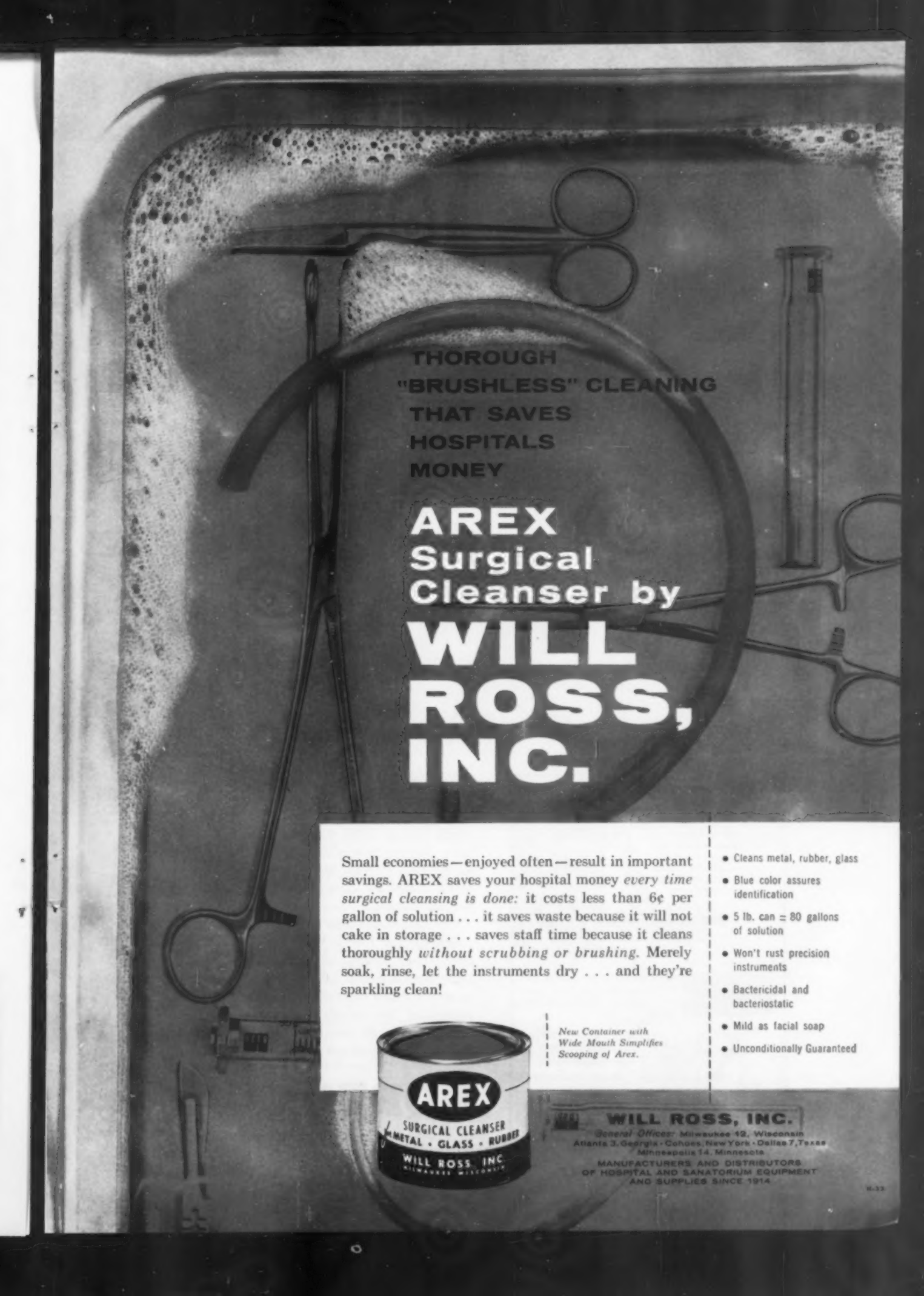
P9910—Ravenswood Model
Drawer with bottle insert

P9912—Michigan Model
Aseptic open compartment

P9900—Bethlehem Model
Removable Plastic basket

P9901—Angelus Model
Dressing stand extends

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"BRUSHLESS" CLEANING
THAT SAVES
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Small economies—enjoyed often—result in important savings. AREX saves your hospital money *every time surgical cleansing is done:* it costs less than 6¢ per gallon of solution . . . it saves waste because it will not cake in storage . . . saves staff time because it cleans thoroughly *without scrubbing or brushing.* Merely soak, rinse, let the instruments dry . . . and they're sparkling clean!
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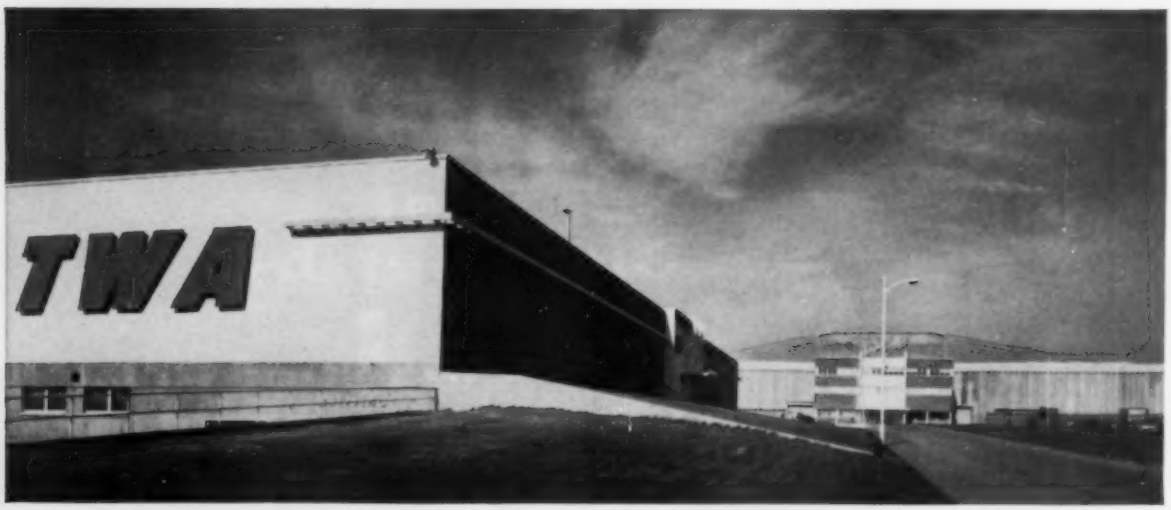
A continuing series of outstanding schools, churches, office buildings, hospitals and industrial structures using NORTON DOOR CLOSERS

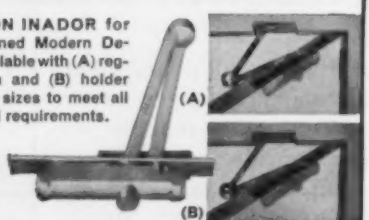
TWA TRANS WORLD AIRLINES EQUIPS NEW BUILDINGS IN KANSAS CITY WITH NORTON DOOR CLOSERS

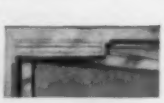


BURNS & McDONNELL ENGINEERING CO., ARCHITECTS AND ENGINEERS • AMMANN & WHITNEY, CONSULTING STRUCTURAL ENGINEERS

Complete Norton Line Meets Every Door Closer Need

NORTON INADOR for Streamlined Modern Design available with (A) regular arm and (B) holder arm...4 sizes to meet all standard requirements.





NORTON 790: New corner design with concealed arms for all type doors, particularly narrow rail doors.

Norton Surface-type Closers are available for all installations where concealment is not essential.

NORTON 703E: Compact surface mounted type...first closer with extruded aluminum alloy shell.

An engine for an airliner or a door closer for the plant which overhauls that engine, both must have one quality in common—dependability—to be acceptable to Trans World Airlines. With that thought in mind, the engineers specified *Norton Surface-Mounted Door Closers* for buildings at Trans World Airlines' new $18,750,000 overhaul base on Kansas City's Mid-Continent International Airport.

The door closers used here by TWA are the modern counterparts of Norton Door Closers still in daily use after serving continuously 20 to 30 years and longer. Other Norton models are available as shown at the left, to serve virtually every door closer need with equal dependability. See the new Norton catalog #57 for full descriptions of the complete line, including important new models. Write for it today.

NORTON® DOOR CLOSERS

Dept. MH-78 • Berrien Springs, Michigan

Result: New products that offer new economies

These recent Lily developments help you speed up service—with less effort, at less cost.

The Man With The Lily Plan is tackling a problem—so he can help drop your costs to a minimum. Such unrelenting efforts have provided volume feeders with a cost-conscious team of new products, plus important improvements on proven products.

For example, Lily* place settings (shown in kit) offer all kinds of economies—from soup to nuts. They're completely disposable, thus eliminating labor costs involved in scraping, washing, drying and storing. They also eliminate need for dishwashers, expense of maintaining them, and additional cost of hot water, soap and detergents.

Simplify service, lighten trays

Lily place settings provide a matched service for nearly every food and beverage on your master menu. They require less storage space, eliminate the expensive problem of breakage, cut time and effort involved in bussing. Lily paper service also simplifies serving and after-service.

Volume feeders of all kinds use Lily place settings to save valuable time, and to reduce fatigue caused by carrying heavy, dish-laden trays.

New Lily exclusive

Lily offers three sizes of molded smooth plates: 6, 9, and 10 in., plus two sizes of compartmented molded plates, 9¼ and 10¼ in. The 9¼ in. plate, made by Lily alone, has that extra rigidity needed for confident one-hand handling. Its "full depth" compartments control portions and costs better, keep foods and companion juices and gravies in place. 10¼ in. plate has same features but allows for larger portions.

Free samples

Lily is constantly striving — through research, through product development, through product improvement — to find new economy measures, new convenience features. We'd be happy to show you how specific findings apply to your operation. We'd also be happy to send you free samples of the products above. Just write: *Lily-Tulip Cup Corporation, Dept. MH7, 122 East 42nd Street, New York 17, New York.* **T.M. Reg. U.S. Pat. Off.*

B.F.Goodrich

New "Surgiderm" glove reduces hand and finger fatigue

A NEWLY-DEVELOPED rubber used in B.F.Goodrich "Surgiderm" gloves makes possible for the first time a glove that combines comfort, sensitivity and strength.

Surgeons and operating room nurses who have tried "Surgiderm" gloves like them because they are so much more comfortable than other surgical gloves. The "Surgiderm" glove is 30% to 50% softer than any regular rubber surgeons' glove. Because it's more pliable, it takes 25% to 30% less force to flex the fingers and hand, a major factor in reducing fatigue.

In addition, the B.F.Goodrich "Surgiderm" glove is long-lasting. It is strong to start with and stays strong even after many sterilizations. It is 36% stronger than an ordinary type of glove *before* use, 67% stronger after ten sterilizations, and can be stored for months with no danger of deterioration.

B.F.Goodrich "Surgiderm" gloves cost no more than many standard gloves now on the market. They are made in sizes from 6 to 10, have rolled wrists which fit snugly over the gown, are brown in color. Sold by hospital supply houses and surgical dealers everywhere. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Company, Akron 18, Ohio.*

B.F.Goodrich ***hospital and surgical supplies***

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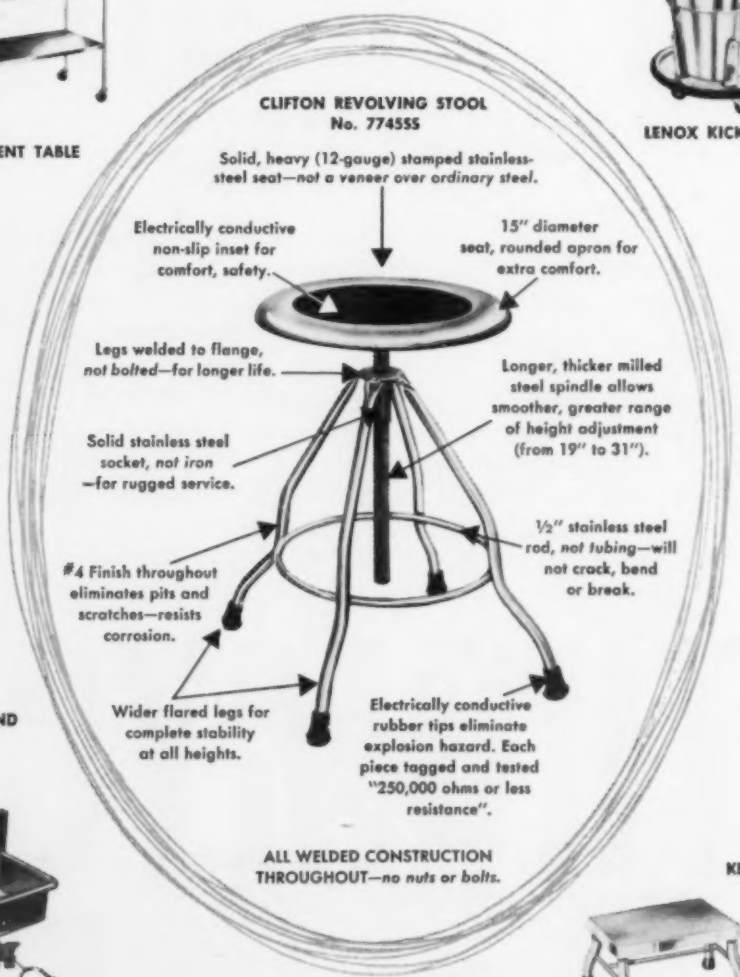
MANHATTAN MAYO STAND

BAKER SOLUTION STAND

WINDSOR SCRUB-UP SINK



LENOX KICK BUCKET

NORTHERN IRRIGATOR STAND

FERGUSON UTILITY TABLE

KELLOGG SPONGE RACK

WINFIELD FOOT STOOL

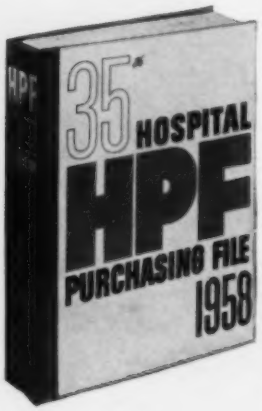
Blickman craftsmanship gives you the *full* benefit of stainless steel. Gauges heavy enough for hard wear. Finishes fine enough for full corrosion resistance and complete asepsis. Rounded corners... invisible seamless welds... completely crevice-free surfaces and joints—wherever required. Blickman alone delivers them all for added convenience, top performance, sure sanitation and decades of durability—*yet it costs no more!* For full details on Blickman's complete line of hospital equipment write: S. Blickman, Inc., 1507 Gregory Avenue, Weehawken, N. J.

BLICKMAN
HOSPITAL EQUIPMENT

Look for this symbol of quality... Blickman-Built

SEE US AT: AMERICAN HOSPITAL ASSOCIATION CONVENTION, INTERNATIONAL AMPHITHEATRE, CHICAGO, ILL., AUGUST 18-21, 1958

here—all in one place



Always turn to HOSPITAL PURCHASING FILE when you choose any equipment or supplies—either familiar items or those you buy only occasionally—for detailed information to help you compare and select. Here, all in one place, are the catalogs of manufacturers who are most eager to help you make wise buying decisions. Catalogs are grouped by hospital departments and simply, accurately indexed to help you find what you are interested in easily and quickly. Keep Hospital Purchasing File on your desk. Be sure your department heads use it to speed up product comparison. Below is a list of catalogs of laundry equipment and supplies, bedding and related items (Section D).

catalogs of suppliers most eager to serve you

e.g.: turn to section D - laundry, bedding, linens

for catalogs of these firms

American Hospital Supply Corporation

American Laundry Machinery Co.

Applegate Chemical Co.

Balyeat Co.

Cash, Inc., J. & J.

Chatham Mfg. Co., Contract Blanket Dept.

Chicago Dryer Co.

Firestone Industrial Products Co., Foamex Division

Huebsch Mfg. Co.

Kohnstamm & Co., Inc., H.

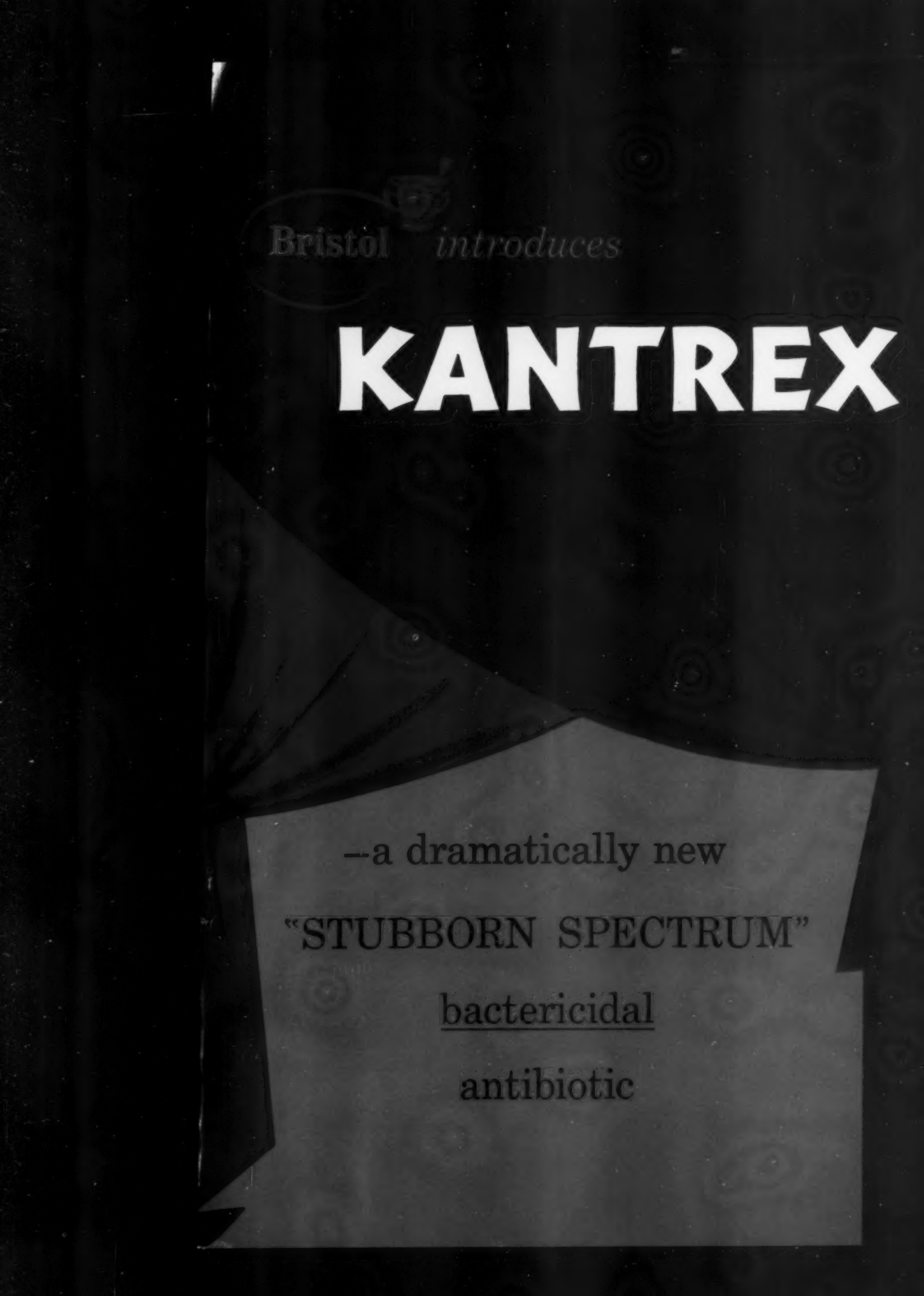
Kuttnauer Mfg. Co.

National Marking Machine Co.

Troy Laundry Machinery Division, American Machine & Metals, Inc.

Voisinet Garment Co.

Webb Mfg. Co.


Bristol introduces
KANTREX
—a dramatically new
"STUBBORN SPECTRUM"
bactericidal
antibiotic

Announced at two-day conference
under auspices of
NEW YORK ACADEMY OF SCIENCES
JULY 10 AND 11, 1958

Chemical, microbiological, pharmacologic and clinical aspects reviewed in 35 papers by eminent investigators. For a complimentary copy of the complete proceedings, write to

Medical Department
BRISTOL LABORATORIES INC.
630 Fifth Avenue
New York, N. Y.

KA

–bactericidal

against a wide variety

of recalcitrant organisms

–even against

resistant staph!

TREX™

Kanamycin Sulfate

–for intramuscular use

TYPICAL CASE HISTORIES

"A THERAPEUTIC TRIUMPH"

*in staphylococcal endocarditis**

L.B., an adult male, was diagnosed as having tricuspid endocarditis with multiple pulmonary septic infarcts, due to a penicillin-resistant *Staphylococcus aureus hemolyticus*. He was acutely ill and, after receiving 24 million units of penicillin a day, plus 2 Gm. of erythromycin, continued a "striking downhill course."

Intramuscular kanamycin (KANTREX) was started at a dosage of 0.5 Gm. t.i.d. for 3 days, after which it was raised to 1.0 Gm. t.i.d. and continued for 5 weeks. Following this, the dosage was lowered to 0.5 Gm. t.i.d. for 2 weeks. No evidence of any kind of kanamycin toxicity was observed during the 7½ weeks of therapy.

A prompt temperature drop occurred by the fourth day of KANTREX therapy. Subsequently, X-rays showed resolution of the septic infarcts.

The patient was discharged as recovered on 2/7/58, and a clinical follow-up since then showed him to be entirely well. This case was described by the investigator as "a therapeutic triumph."

*Sol Kats, District of Columbia General Hospital, Washington, D.C.: Personal communication.

Among the pathogenic organisms susceptible to KANTREX are various strains of *Staph. aureus* and *albus, Proteus, A. aerogenes, Klebsiella pneumoniae, Salmonella, Shigella, E. coli, paracolobacterium, Pseudomonas* and *enterococcus.*

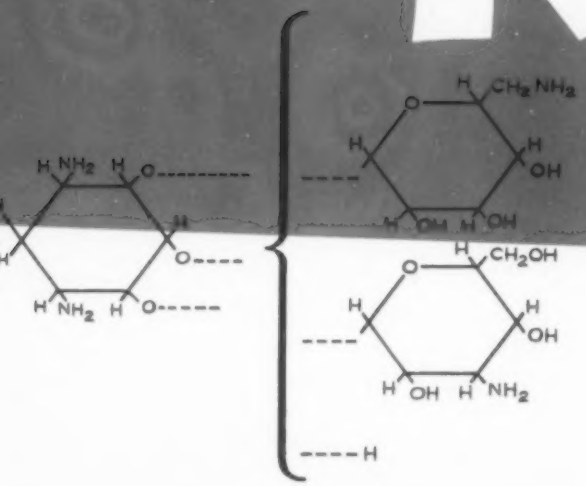
Preliminary studies indicate that KANTREX is a promising agent against *Mycobacterium tuberculosis,* including streptomycin- and isoniazid-resistant strains.

A new "stubborn sp

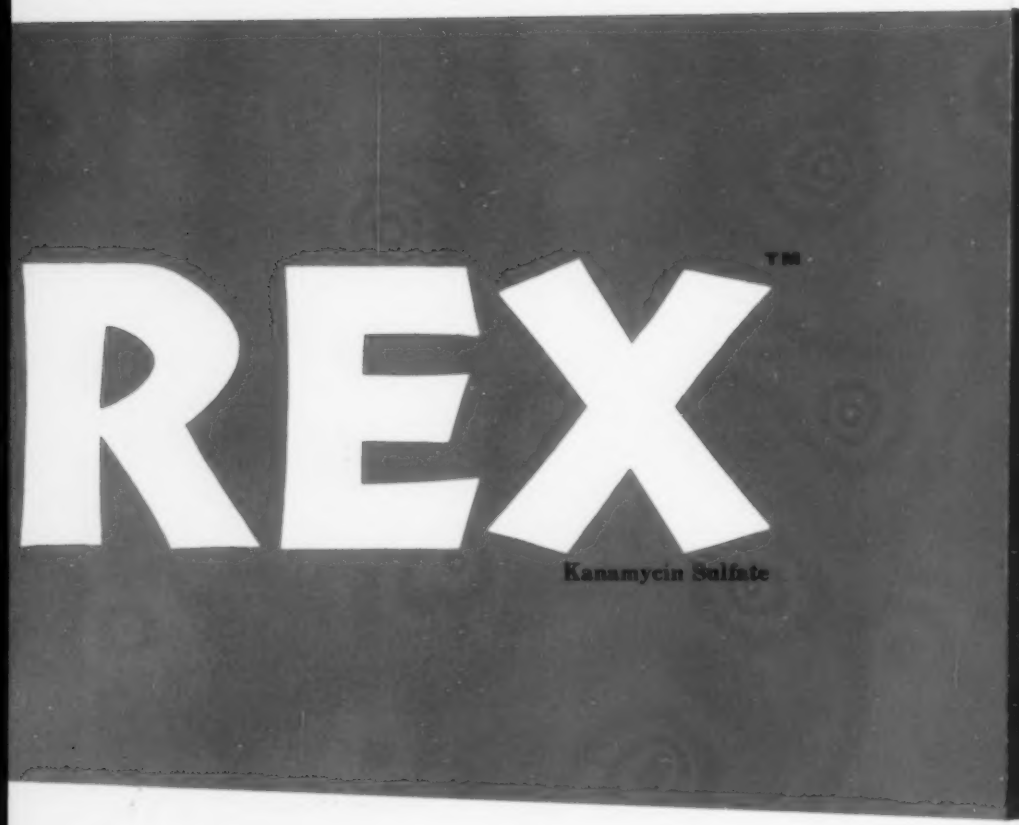
Clinical studies show that many stubborn organisms resistant to chloramphenicol, penicillin, streptomycin, erythromycin, chlortetracycline, tetracycline, oxytetracycline, oleandomycin, and novobiocin—singly or in combination—are sensitive to KANTREX.

rn spectrum" antibiotic–

KAN



KANTREX—an antibiotic derived from *Streptomyces kanamyceticus*—is bactericidal against a wide variety of Gram-positive and Gram-negative organisms, including strains of *Micrococcus pyogenes* var. *aureus*—the most notorious of the "resistant staph."



FROM "TERMINAL" STATE TO COMPLETE RECOVERY

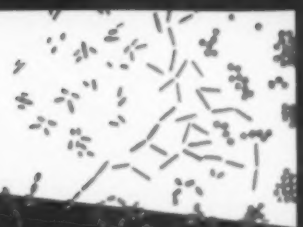
*in septicemia and pneumonia**

A.B., a 1-year-old girl, had received chloramphenicol, erythromycin, penicillin, and bacitracin without effect, for septicemia and pneumonia due to *Staphylococcus aureus.*

KANTREX was started on the 18th day of her illness in a dosage of 15 mg./Kg. a day for the first day, and 10 mg./Kg. for 25 days, in divided doses. Total dosage for the 26 days was 1.68 Gm.

A "dramatic improvement" was noted immediately after KANTREX was started. Although the patient seemed "terminal" before KANTREX was administered, she showed rapid improvement, and X-ray evidence of the disease gradually disappeared. She was discharged "completely well." No toxic reactions were observed.

*E. M. Yow and O. Monzon, Dept. of Medicine, Baylor Univ. College of Medicine, Houston, Tex.: Personal communication.



for resistant organisms–

KANTREX™

Kanamycin Sulfate

Indications

Indications for KANTREX include infections due to kanamycin-susceptible organisms:

Respiratory infections: laryngitis, tracheitis, bronchitis, pneumonitis, broncho-pneumonia, lung abscess, pleuritis, empyema and bronchiectasis.

Urinary tract infections: acute and chronic pyelonephritis, cystitis.

Soft tissue infections: wound infections, abscesses, cellulitis, osteomyelitis, blood stream infections.

Dosage

Adults: Average daily intramuscular dose 1 to 2 Gm. in 2 to 4 equally divided doses.

Children: Average daily intramuscular dose 15 to 30 mg. per Kg. in 2 to 4 equally divided doses.

Precaution

In the course of extensive clinical trials, signs of renal irritation and skin eruptions (which disappeared on cessation of therapy) were occasionally noted. Signs of eighth nerve dysfunction – tinnitus, vertigo and loss of hearing – were observed in a few patients. These patients were predominantly over forty-five years of age; all had received 18 grams or more of KANTREX. In this latter respect it would appear that KANTREX has less toxic potential than streptomycin.

Supply

KANTREX is available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX (kanamycin sulfate) 0.5 Gm. in 2 ml. volume.

KANTREX (kanamycin sulfate) 1.0 Gm. in 3 ml. volume.

Also available: KANTREX (kanamycin sulfate) Capsules, 0.5 Gm. for preoperative bowel antisepsis; bottles of 20 and 100.

Comprehensive literature available on request

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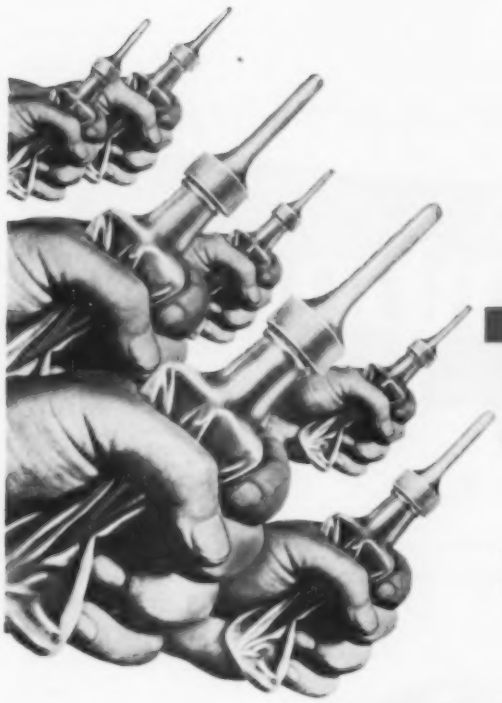

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1. "Standard vs Disposable Unit Enema": Rainier, W. G.: and Lee, B., Hospitals 31:50, Jan. 1, 1957
2. Swinton, N. W., Surg. Clinics No. Am. 35:833, 1955
3. Palmer, E. D., "Clinical Enterology," Hoeber-Harper, 1957

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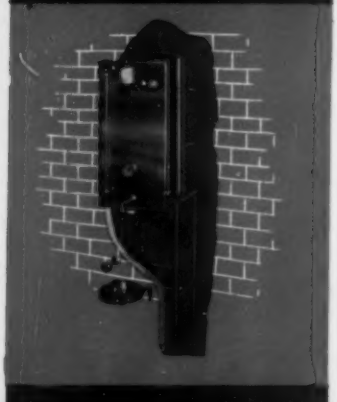

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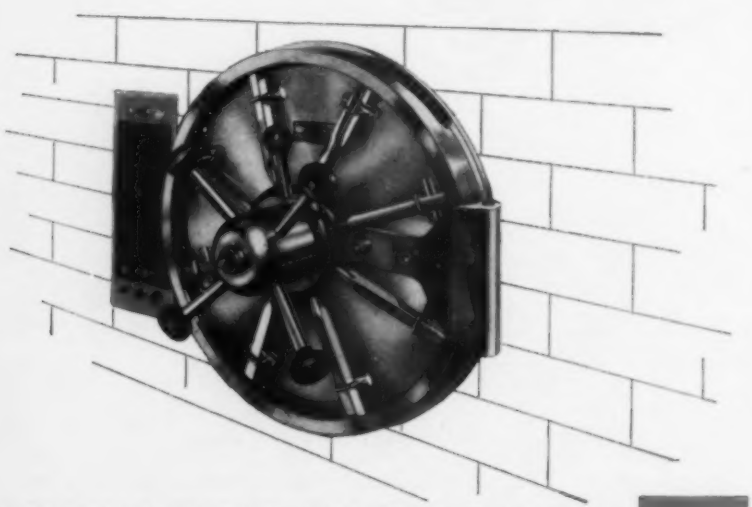

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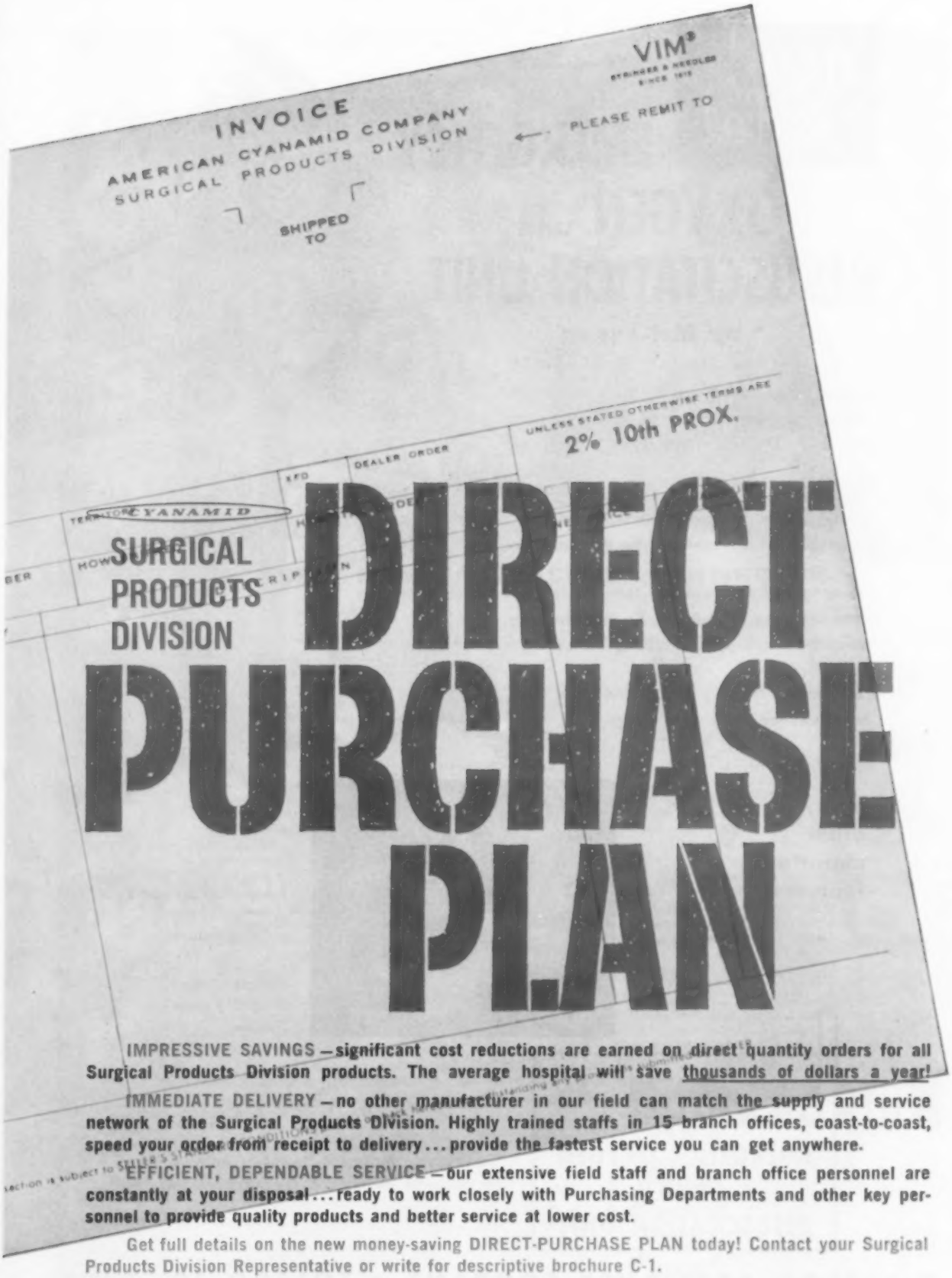

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*Southern Methodist University Men's Dormitory	Dallas, Tex.	George L. Dahl–Dallas, Tex.
*Southern Methodist University Women's Dormitory	Dallas, Tex.	George L. Dahl–Dallas, Tex.
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How *high velocity* solves problem of *flexibility* in the Medical Towers

When the new Medical Towers Building in Houston, Texas was planned, the key air conditioning problem was flexibility. Professional office areas had to be subdivided *after* the building was completed. Here's how an Anemostat dual duct high velocity air distribution system solved the problem.

As shown in the diagrammatic sketch, a system of perimeter take-offs from the hot and cold ducts enables each doctor to provide the exact temperature he wants. Temperatures in the various rooms of each suite of offices can be varied. Air distribution is draftless, comfortable, perfectly suited to tenants' needs.

The Anemostat All-Air High Velocity distribution system offers further important advantages. It can be used with smaller than conventional ducts. It can be installed in less time and at less cost. It requires no coils, thus eliminates leakage, clogging and odors.

ARCHITECTS—Attention Please:
Anemostat round, square and straightline diffusers with high velocity units are adaptable to a wide variety of architectural designs.

Architects: Golemon and Rolfe, AIA, Houston
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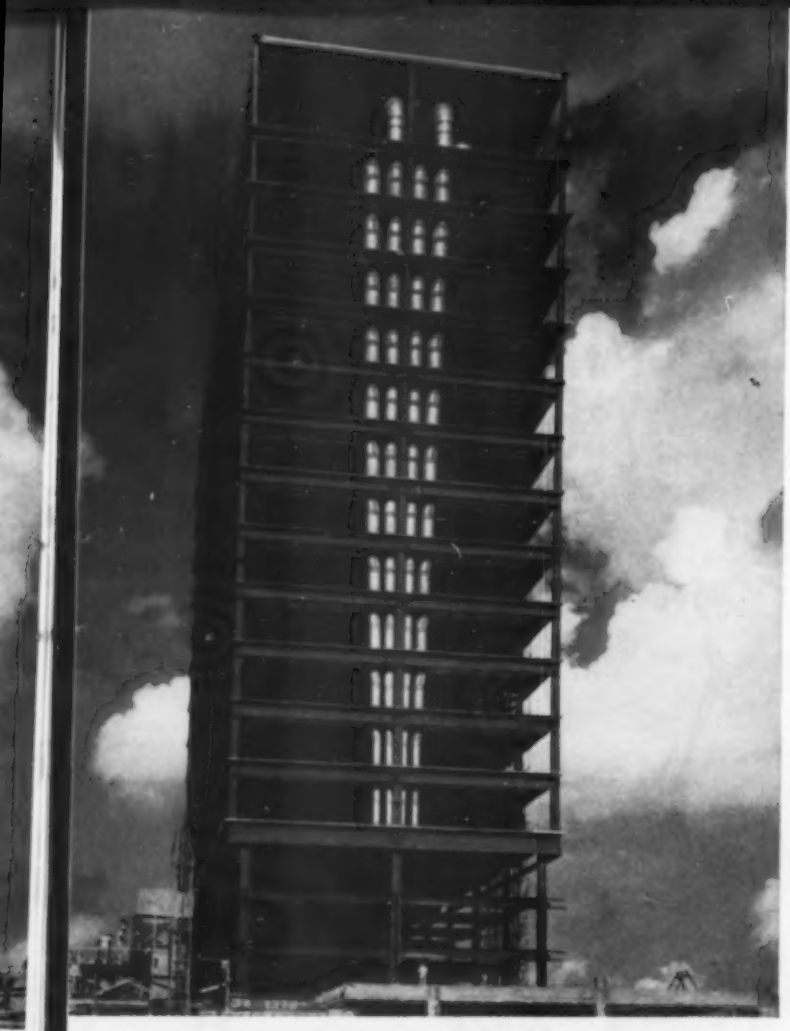
Consulting Engineers: Bernard Johnson and Associates
General Contractor: Tellepsen Construction Co.
Air Conditioning Contractors: Straus-Frank Company

Anemostat HPE units and duct connections installed in office before construction of ceiling and walls

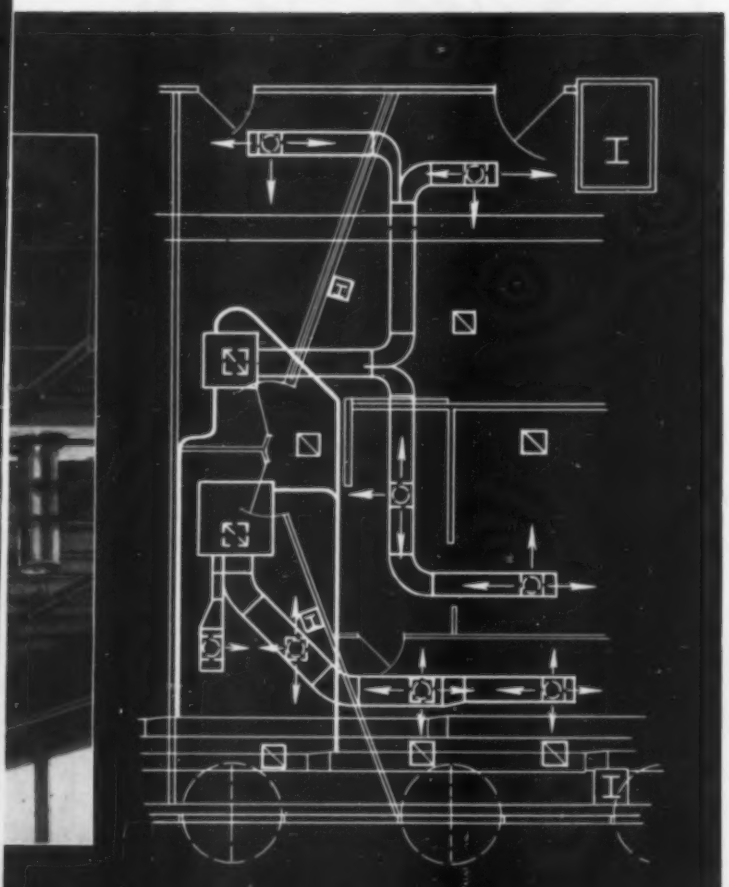
AC 1348



◀ Note how locating of hot and cold ducts saves space in new Medical Towers Building, Houston, Texas

View of lobby showing Anemostat Air Diffusers

View of professional reception room



◀ Layout of typical suite

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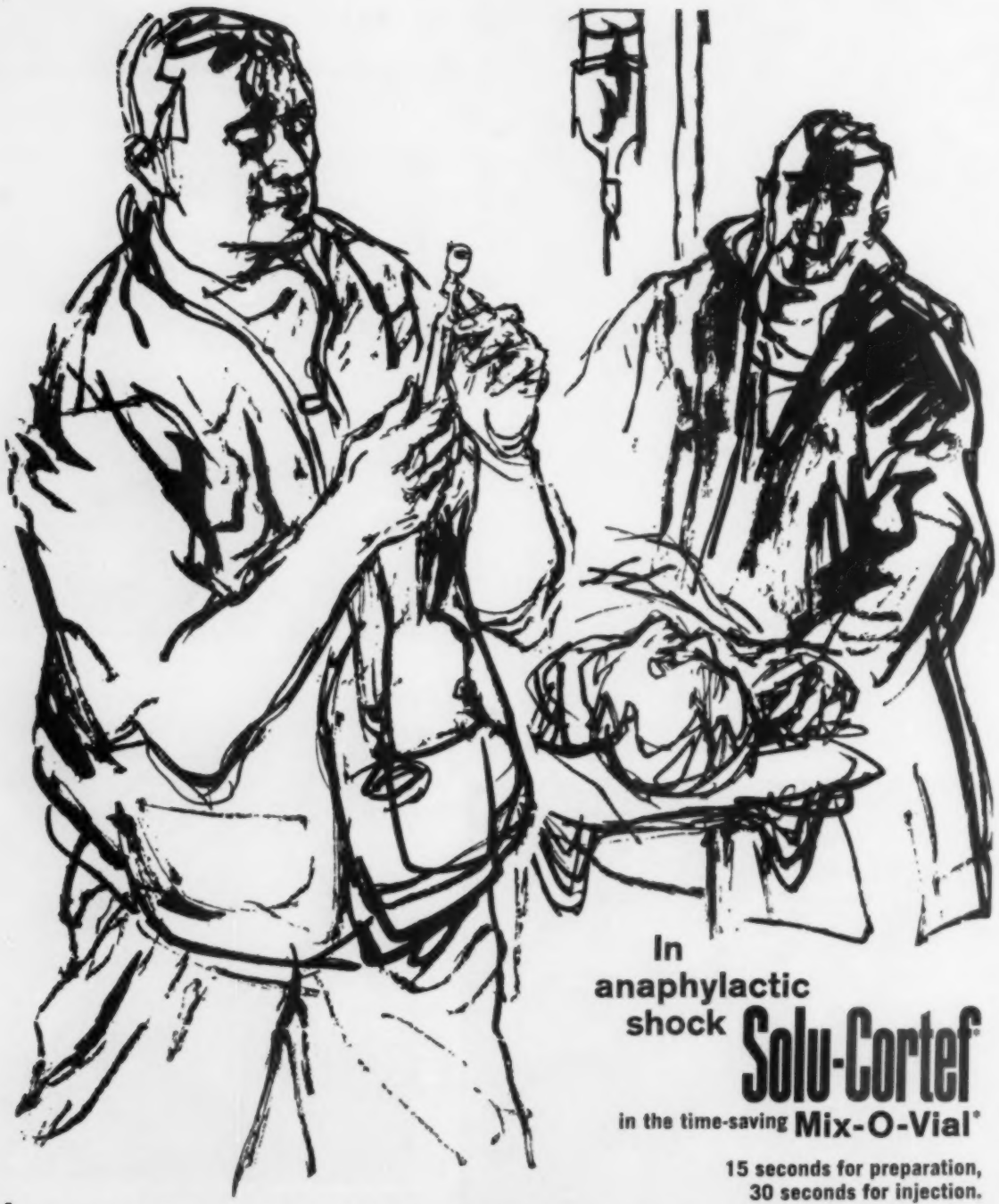


In anaphylactic shock Solu-Cortef®

in the time-saving Mix-O-Vial®

15 seconds for preparation,
30 seconds for injection.

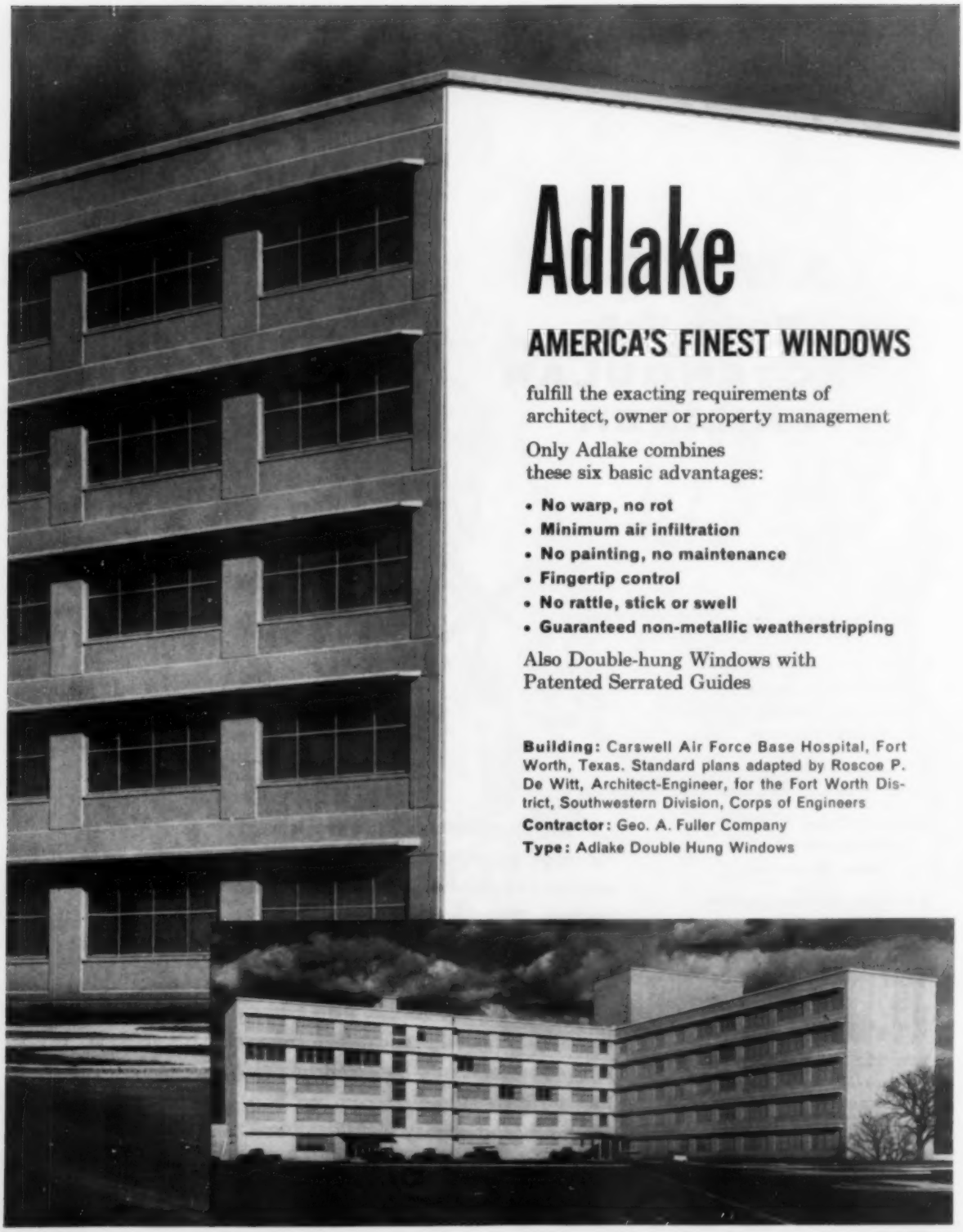
In acute anaphylactic emergencies, when the body reacts violently to drugs, antibiotics, or sera,[1] swift action can save a life that hangs by a thread. Injectable Solu-Cortef (hydrocortisone sodium succinate) rapidly combats shock and reverses hemodynamic collapse. Even when epinephrine and antihistaminics fail, and only a fair response can be obtained with ACTH, Solu-Cortef is usually dramatically effective.[2]

Administration and dosage: In acute anaphylactoid reactions, Solu-Cortef may be given in 100 mg. or 250 mg. doses, as indicated by the severity of the condition, and repeated at intervals of 1, 3, and 6 hours. Each Mix-O-Vial contains 100 mg. Cortef (as 133.7 mg. hydrocortisone sodium succinate) for intravenous or intramuscular use. If not injected immediately after mixing, refrigerate and use within 24 hours.

Supplied: As a 100 mg. and a 250 mg. Mix-O-Vial.

References: 1. Hull, E.: Kansas City M.J. 33:19 (March) 1957. 2. Grater, W. C.: Ann. Allergy 13:191 (March-April) 1955. ®Trademark, Reg. U. S. Pat. Off.

Upjohn



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Building: Carswell Air Force Base Hospital, Fort Worth, Texas. Standard plans adapted by Roscoe P. De Witt, Architect-Engineer, for the Fort Worth District, Southwestern Division, Corps of Engineers

Contractor: Geo. A. Fuller Company

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SMALL HOSPITAL QUESTIONS

Ratio of Care by R.N.'s

Question: What proportion of nursing care should be by registered nurses?—T.N.A., Md.

ANSWER: The acceptable proportion may vary widely among communities, hospitals and even floors or units within the same hospital, according to the nature of the case load. Generally speaking, experience in community hospitals in recent years has indicated that half or more of nursing personnel may be other than registered nurses, provided that practical nurses, aides and attendants are properly trained and duties within the unit are carefully assigned so that all classes of personnel are performing services for which they have been adequately prepared. Of course, this is not the same thing as saying that half or more of nursing care should be rendered by other than registered nurses, since only the registered nurses may undertake the care of critically ill patients, the performance of difficult technical procedures, and the supervision of nursing care on the floors. For more detailed information, hospitals may obtain publications on staffing the nursing department from the U.S. Public Health Service, Division of Nursing Resources, and the National League for Nursing.

When Not to Admit Patients

Question: A doctor who is not a member of our staff asked if he could admit a patient, at a time when he could not get a bed in the hospital where he works. We allowed this. Were we right?—B.X.C., Mass.

ANSWER: In an emergency, of course, the patient must be admitted, but if you have an organized staff you should have explained to the physician that the patient would have to be referred to a qualified physician with staff privileges. Of course, if you are an accredited hospital, or seeking accreditation, only regularly appointed staff members may admit patients to the hospital. The "open staff" hospital to which any licensed physician may admit any patient for any purpose is a vanishing phenomenon in our society; medical and hospital authorities agree that organized hospital staffs are necessary to ensure high standards of patient safety and patient care.

Under unusual circumstances, it is sometimes advisable to give a non-staff physician temporary privileges as a consultant, to attend a particular patient. The staff by-laws may provide for such contingencies; however, under these circumstances, the consultant must be familiar with and agree to abide by all rules and regulations governing other staff members, and the appointment, like all others, should be made through regularly constituted medical staff channels.

Releasing Autopsy Report

Question: When a newborn infant died in the hospital recently, an autopsy was performed by our pathologist. The baby's father has asked for the autopsy report, but the physician in the case has requested that the report should not be released to the family. What should we do under these circumstances?—B.K.D., Mich.

ANSWER: See your lawyer! Courts have differed in their rulings on questions involving the compulsory release of autopsy information in the various jurisdictions, and the hospital attorney should be consulted before this problem is resolved.

Intensive Care Is Feasible

Question: Is it possible or advisable to establish an "intensive care area" in a 100 bed hospital?—N.W.D., Ore.

ANSWER: Certainly it is possible, though the practice at present is restricted for the most part to hospitals in the larger size groups. The question should be resolved in cooperation with the medical staff. Do doctors feel the need for providing an area in which more intensive medical and nursing supervision may be given economically? Advocates of intensive care areas even for smaller hospitals point out that these hospitals are already divided into departments of medicine, surgery, obstetrics and pediatrics, and that the provision of a single area for intensive supervision of all critically ill patients simplifies rather than complicates hospital organization. However, the decision should not be made by the administration alone, but only after thorough review with the medical staff—and primarily on the basis of what is best for the hospital's patients rather than for the staff or the business office.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Charge for Standby Service

Question: It has been our practice to make a "standby charge" for oxygen when the physician orders equipment held in readiness for possible use, even when oxygen is not actually required and administered. Recently a patient objected strenuously and refused to pay this charge, accusing the hospital of "profiteering" and pointing out that the oxygen was never actually used. Should we insist on collecting this charge?—S.E.O., Pa.

ANSWER: By all means. It should be possible for you to demonstrate that the equipment and supplies were organized and held in readiness for the patient's benefit—and that the patient did in fact benefit from the availability of oxygen and oxygen service, as ordered by the physician, even though oxygen was not actually administered. Furthermore, the cost of this "readiness to serve" should be demonstrable. Unless the charge was out of all proportion to the cost, the patient who refuses to pay is being unreasonable, and the item should be handled as any other unpaid charge would be handled. The charge for such "standby" service might conceivably vary from as little as $1 to as much as $5 a day.

Pharmacy Committee

Question: We are organizing a pharmacy committee on the medical staff, with membership representing the principal medical departments, and including the pharmacist. Should the administrator be a member of this committee? Should the nursing department be represented? — R.F.T., Okla.

ANSWER: In a recent survey of 500 hospitals having such committees, the average number of members on the committee was four. Fifty-four per cent of the committees included the administrator as a member. Other members, as reported by the participating hospitals, were: pharmacist, 74 per cent; internist, 67 per cent; surgeon, 62 per cent; other physician, 47 per cent; obstetrician, 34 per cent; pediatrician, 29 per cent; anesthesiologist, 13 per cent; purchasing agent, 9 per cent; nurse, 7 per cent; otolaryngologist, 6 per cent; other, 6 per cent.

The simple beauty of the new wing of St. Luke's Hospital is maintained by the trim appearance of General Electric *Thinline* air conditioners mounted inside the windows.

163 General Electric Thinline Air Conditioners Cool and Filter the Air in This Wisconsin Hospital

"AIR CONDITIONING means more than personal comfort to us," says Karl York, administrator of St. Luke's Hospital in Racine, Wisconsin. "Patients relieved of discomfort are better patients, and the better the patient, the quicker the recovery.

"Our employees are happier and more efficient, too."

General Electric *Thinline* air conditioners were donated to St. Luke's by a former patient who had sweltered in a hospital bed through many hot, humid summer days. Air-borne dust, dirt and pollen are almost entirely eliminated.

No one swelters at St. Luke's today. Both new and old sections of the hospital are cooled and ventilated by an air conditioning system that uses *Thinline* units in four different types of installations.

Two *Thinline* air conditioners are built into glass block walls; one is mounted in a metal casement window; six others are mounted completely outside double-sash windows; and the remaining 154 are inside double-sash windows.

This system assures cool comfort and maximum cleaning convenience for each cooling zone in the building.

Whether yours is a new or existing building, why not look into the advantages of air conditioning with General Electric *Thinline* units. Various models are available from 5600 to 14,500 BTU* capacity. There's one just right for your cooling needs.

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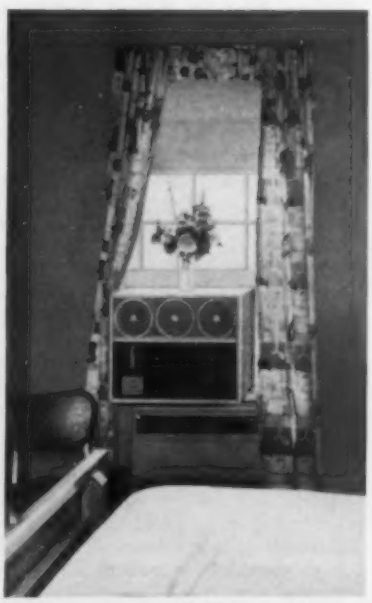
*Cooling capacities are tested and rated in compliance with ARI (Air Conditioning and Refrigeration Institute) Standard 110-58 and are stated in BTU's (British Thermal Units).



Window-mounted *Thinline* units allow enough light to keep hospital rooms bright and cheerful. Many hospitals rent these units to patients as an added source of revenue.

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In laundering, dry cleaning or rug cleaning...

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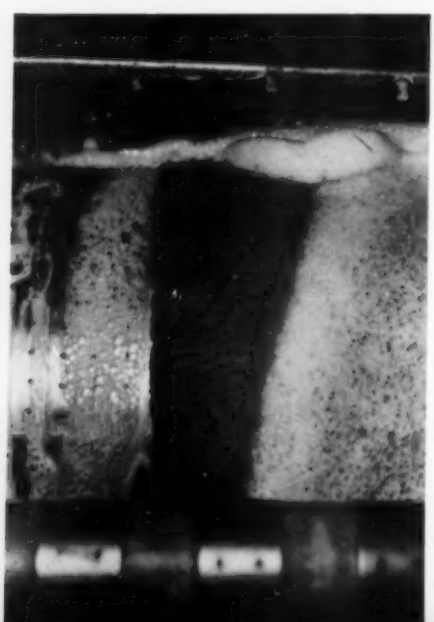

Ultimately, the reason for laundering, dry cleaning or rug cleaning is to remove soil from fabrics, then finish them properly. All successful methods involve both chemical and mechanical action. The most efficient use of these principles is the basic consideration in machinery design.

Here at American, our research and development people are continually testing chemical properties, new principles of mechanical agitation, the effects of heat and pressure—to the end that we are confident all of our products make full use of the latest scientific knowledge available.

The fact that we design and build laundry, dry cleaning and rug cleaning machinery is a distinct *advantage*. Often a dry cleaning discovery leads to a laundry improvement, or a laundry development is applicable to rug cleaning, and vice versa. Soil removal is the common thread.

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No Dream ...this *Theme* hospital room by Simmons

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In the room illustrated, furniture color is soft Heather Green. Desk-dresser is made up of modular basic three-drawer small case unit under a 58½" long top. Bedside Cabinet 30" high means greater patient comfort with the Single-Action Vari-Hite Hospital Bed. Textolite table tops, Naugahyde upholstery and famous Beautyrest mattress built especially for hospitals mean that comfort and beauty go hand-in-hand with durability. You'll find *Theme* costs are surprisingly moderate, too. It's the common-sense solution to building, modernizing, decorating problems.

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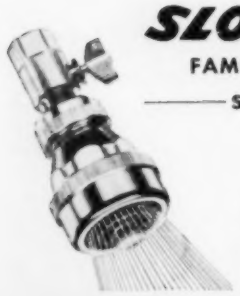

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HILL-BURTON OUTLOOK BRIGHT

The Hill-Burton hospital construction program next year will have at least as much money to spend as it has this year, and likely a great deal more.

Complete assurance that the program would be well taken care of came in Sen. Lister Hill's Senate appropriations subcommittee, which approved $211,200,000—all the law allows—in contrast to the $121,200,000 recommended in the bill as it passed the House.

The full appropriations committee accepted the increase without question and no problem is expected in the Senate itself. Then a compromise will have to be worked out in the Senate-House conference committee. However, parliamentary rules dictate that the figure can't be set any lower than the lowest recommended by either chamber. So H.-B. is assured at least as much as this year—$121,200,000.

The prospect is considerably more encouraging than it was earlier in the year when the Budget Bureau, under extreme pressure, was at last forced to let the department ask for $75 million for next year. Before the appropriations bill got out of the House committee, however, the Budget Bureau and the White House had a change of heart, and sent up word that $121,200,000 was all right with them. That's what the House then approved.

So in less than five months, the figure has been about tripled.

In reporting out the $211 million, the Senate committee commented:

"**Evidence of the need** for construction of additional health facilities is readily available. Plans submitted by state agencies . . . show the need for 1,211,141 additional hospital and nursing home beds. In addition, our additional population increase alone requires approximately 36,000 additional hospital and nursing home beds each year. It is also estimated that approximately 22,000 hospital beds become obsolete each year and require replacement, requiring 58,000 beds additional each year to hold the line.

"**The provision of $210,000,000** for construction of new hospital beds will provide about 31,800 beds and it is estimated that not more than 20,000 additional beds will be constructed with funds outside the Hill-Burton program, for a total of 51,400, or 6600 under the number required to hold the line, adding to the backlog of requirements."

In addition to the figures cited, $1.2 million is approved for research on hospitals, to make up the total of $211.2 million.

The Senate committee also went all out for other health programs. For example, research funds were increased about 45 per cent over money approved by the House.

FORAND BILL HEARINGS

Congress is moving rapidly toward a decision on the most controversial piece of health legislation of the session—the Forand bill—after two weeks of all-day hearings before the House ways and means committee.

Dr. James V. Lowry has been appointed chief of the Bureau of Medical Services of the Public Health Service, with the rank of assistant surgeon general. He succeeds Dr. John W. Cronin, who died suddenly last March. Dr. Lowry, who has been deputy chief of the bureau since November 1957, entered the Public Health Service in 1937.

Dr. James V. Lowry

The bill would offer surgical care and 120 days of hospital-nursing home care annually to social security beneficiaries and their dependents, financed by increases in Old-Age and Survivors Insurance payroll taxes. Taxes for employer and employe would go up one-half of 1 per cent, and for the self-employed, three-fourths of 1 per cent.

As anticipated, opposition was led by the professional associations, who received an effective assist from Secretary Folsom, talking for the Administration. Support came mainly from welfare groups and labor representatives.

Testifying for the American Hospital Association were Drs. Martin R. Steinberg and James P. Dixon, and Ray Amberg, president-elect of the association. They testified on several other social security issues as well as the Forand plan.

The American Medical Association firmly restated its position of complete opposition to the Forand bill and any other legislation of this type. The A.M.A.'s position, well publicized prior to the hearings, was:

First, no such radical experiment is needed because voluntary health insurance is making rapid progress in reaching those past 65 years of age.

Second, the Forand bill would project the federal government deeply into the medical care picture by having the U.S. set hospital and doctors' fees.

Third, once the Forand bill was enacted there would be no holding the line against total national compulsory health insurance.

The American Nursing Home Association also showed up to ask for more liberal U.S. grants for public assistance but to oppose the Forand bill. Said A.N.H.A. President Ira O. Wallace: "Although our nursing homes would stand to profit as much or more than any other group from a program such as this, we would desire to see a further exploration and the further expansion of medical benefits through privately administered programs and through the cooperation of state governments. . . . We are opposed to the federal government contracting directly for the medical, hospital and nursing home care of O.A.S.I. beneficiaries."

Secretary Folsom guardedly suggested that the Administration would accept cost-of-living increases for O.A.S.I. beneficiaries, to be financed by increasing the amount of income to be taxed from $4200 to $4800. In Congress a

widespread demand for such increases forced the hearings on the social security law and gave Rep. Aime J. Forand (D.-R.I.) the opportunity to have his hospitalization bill considered.

Secretary Folsom did not refer to the Forand bill in his prepared testimony, but when asked his views on it by Rep. Forand said flatly that he personally and the Administration were opposed to it. He explained that if the committee were actually interested in the Forand idea, action should be deferred at least until a special committee now investigating social security financing completes its report, due by next December 31.

A spokesman for the American Public Welfare Association supported the Forand bill, as did several individuals in the welfare fields.

As the hearings progressed, comments by Chairman Wilbur Mills (D.–Ark.) virtually confirmed that some sort of social security bill would be voted out by his committee in time for passage before adjournment. However, he implied that its provisions would be limited, possibly to no more than the following:

1. A slight increase in federal contributions to the four categories of public assistance cases–the needy aged, the blind, dependent children, and the totally and permanently disabled.

2. Extension of federal public assistance to a fifth category–all the indigent who do not fit in the above four groups–if a sufficiently restrictive definition can be worked out to hold down costs.

3. Authority for states to distribute federal medical payments under public assistance in any manner they elect, thus freeing a number of states from present restrictions that are depriving them of their fair share of U.S. medical funds.

Comments from Chairman Mills and questions asked by members of his committee suggested that the Forand bill had only nominal support from them. With the exception of Rep. Forand himself, who questioned every witness who might have been sympathetic, members took little interest in his proposal.

If a mild social security bill comes out of the committee, prospects are that it will pass House and Senate with no trouble whatever. However, if the Forand measure should be included, bitter debates are in store in both bodies, with always the possibility the entire measure will be defeated.

MEDICARE

The military dependent medical care program, not yet two years old, narrowly missed disaster in the House. At this writing it appears to have been saved, but the final verdict won't be in until the Senate-House conference committee ends its work on the Defense Department appropriation bill, probably about mid-July.

The trouble started when a House subcommittee, acting on misinformation or misunderstanding, decided that care in civilian hospitals and from civilian doctors was costing far more than in military hospitals.

To force the department to make more use of military facilities, the subcommittee cut the budget request for the civilian phase of Medicare from a requested $71.2 million to $60 million. That would have been bad enough, but not fatal; the department, as it is doing this year, could use money from other accounts.

But to make sure civilian Medicare actually was cut back, the subcommittee also instructed the department not to spend a dime more than the $60 million.

If this restriction remained, Medicare officials hastily calculated, there would be two major results:

1. All dependents anywhere near military facilities would have to use them, and give up their civilian hospitals and physicians.

Dr. Vane M. Hoge, assistant surgeon general of the Public Health Service since 1949, has been appointed executive director of the Hospital Planning Council for Metropolitan Chicago. He will assume his new duties on September 15.

2. What was left of the civilian program would have to be drastically cut back by placing strict limits on the types of treatment that would be allowed. In consequence, thousands of dependents would have to go without medical attention or pay for it themselves.

On the floor of the House, just before the vote on the appropriation bill, sponsors of the Medicare restrictions, particularly Chairman George H. Mahon (D.-Tex.) of the subcommittee, realized that they were about to pull down the roof.

For technical legislative reasons the restrictions were not taken out of the bill at that time, but members of the subcommittee agreed to accept any reasonable changes the Senate might make to preserve civilian Medicare.

In the Senate committee, American Hospital Association, American Medical Association, and the Defense Department itself pleaded for Medicare.

Military officials said that if the restrictions were cut, Medicare would have to be dropped and an entirely new and limited program started "from scratch." As a compromise, the military proposed to:

1. Offer only military medical care to families living on military bases or in government housing near them, where there was adequate hospital space and staff.

2. Prohibit certain types of medical care in civilian facilities, probably tightening up on elective surgery.

3. If the first two restrictions failed to channel enough civilians to military hospitals, increase the charges against civilians (now the first $25) in civilian facilities but make no increase in military charges.

Whatever compromise was to be reached, it was certain that not all dependents would be allowed free choice of hospital and physician, as they are now, but that Congress would allow sufficient money to continue Medicare in somewhat its present form.

NOTES:

In a clarifying ruling, Internal Revenue Service says that doctors on full-time staff basis with hospitals do not have to include as income checks made out to them by patients but turned over to the hospital.

From now on doctors may not include in their claims to Medicare the cost of all drugs furnished or prescribed for maternity patients; however, they still may list cost of drugs administered parenterally.

Headed for enactment is a bill to make proprietary nursing homes eligible for mortgage guarantees under F.H.A.; mortgages would cover up to 75 per cent of the cost, with interest at no more than 4¼ per cent.

Also scheduled for passage is a bill to authorize long-term, low-interest loans to communities for building public and nonprofit facilities, including hospitals, nursing homes, and state medical schools.

A bill extending the Hill-Burton program for three years beyond its scheduled retirement date of next June 30 is assured of enactment; it was introduced by Chairman John Bell Williams (D.-Miss.) of the House subcommittee that held hearings on Hill-Burton.

Also moving ahead, and on an apparently clear course, is a bill to allow approved Hill-Burton applicants to accept long-term, low-interest loans in place of grants; it was introduced at the request of some religious groups that believe U.S. grants are an infringement of the principle of separation of church and state.

The Modern Hospital
JULY 1958

LOOKING AROUND

Audit

THE American Institute of Management, a not-for-profit business located in New York City, has just conducted its first management audit of a hospital and announced in a press release that the hospital is "excellently managed." The institute gave Baptist Hospital of Pensacola, Fla., an over-all rating of 7960 points out of a possible 10,000, the release said. The hospital and its administrator, Pat N. Groner, were praised for its financial management, planning for community needs, and for its "forward looking attitude." The institute does not attempt to judge patient care as such, it was explained, but only the methods of control and other factors which are the responsibility of management. "Here, too, Baptist Hospital measured up to excellent standards, with proper weight of qualifications in its medical staff and adherence to good control procedures to check on medical care," the announcement said.

The institute does systematic studies of business management performance, the press release explained, and in studying Baptist Hospital it applied a 10 category system similar to the method used in industry, "emphasizing that all types of management concerned with controlling men and money must apply similar management principles while using different technics."

Of course, we're delighted that Baptist Hospital and Pat Groner are controlling men and money so efficiently and got such a high score, but we're curious about one statement in the release. "There seems to be no field of American enterprise in which good management is in greater need or more difficult to achieve than in hospital service," this said. "It is questionable if management training, policies, practices and procedures have kept pace with the growth of hospital facilities and services."

If this is the first management audit of a hospital ever conducted by the institute, how does it know? There's a little implication here that the institute figured hospital management would be a shambles and was cracked up to find everything at Baptist in such good shape.

Administration on Trial

AS HE works away at his everlasting task of selecting and ordering the best means for achieving stated ends, the administrator is constantly resolving conflicts. In the hospital setting, economy collides with service; the worker who wants a raise can be satisfied only at the expense of the patient who pays the bill; the doctor demanding freedom is here to stay and unlikely to change, and so is the trustee demanding control; the modern concept of democratic management abrades the authoritarian tradition of medicine.

In a recent essay on administration,* Professor Sidney Hook, chairman of the graduate department of philosophy at New York University, observed that administrative mechanisms are generally applied in situations where one encounters "conflicting claims to security and freedom, efficiency and happiness, safety and adventure, greater profit and greater service."

When we are dissatisfied with the way an administrator behaves we call him a bureaucrat, Professor Hook said. "In this sense, bureaucracy is a disease of administration," he added. "All organizations are subject to it—whether government, business, union, church, or university."

The argument, still heard on occasion, that medical institutions should be administered only by physicians is well known to Professor Hook, and it has its counterpart in governmental administration. "This view is familiar to us in the Platonic conception of the rule of the philosopher-king, or the rule of the expert," he stated. "A second view is the democratic one, which takes its chances with inefficiency but insists on diffusing power and yet making it more responsive and responsible."

Examining the charge that democratic administration hampers efficiency, Professor Hook acknowledged that consultation, give and take, and establishing consensus are time-consuming processes: "Measured by time spent or wasted, it is more efficient to entrust one person with policy decision. Yet sometimes it is possible to pay too high a price in human dignity for such efficiency. Furthermore, there are many kinds of efficiency. . . . Even in cases where production is taken as an index of efficiency, it may turn out that production is in turn dependent upon employe morale, satisfaction, *esprit de corps* resulting from a consciousness of effective participation, of co-responsibility for operation of the enterprise."

In a passage that would make instructive reading for those who are concerned about "lay interference" in medical affairs, Professor Hook denied that it is impossible for nonexperts to evaluate the performance of experts. "There is of course a danger that untrained individuals will presume to talk about what they do not know and

*Hook, Sidney: Bureaucrats Are Human, Saturday Review of Literature, May 17, 1958.

about what they are not competent to assess," he said. "But one does not have to be an expert in order to judge the handiwork of experts. Surely I can judge whether the soup is good even though I cannot prepare it. We don't have to be a general to know who is a good general, a watchmaker to tell a good timepiece from a poor one, a pilot to know who brings his passengers safely to port. A wise use of things depends upon knowledge of them, but not all knowledge of things leads to a wise use of them."

Professor Hook is skeptical about administrators who are convinced that their expertness gives them the right to manage. "Bureaucracies acquire power not so much by usurpation as by gradual use and wont," he warned. "Nor do they always succumb to the specific temptation of furthering their material interests. Not infrequently it is the temptation to manipulate human beings, the refusal to brook contradiction, the desire to get things done quickly which exercises the corrupting influence.

"There is a type whom we can identify as the managerial autocrat who enjoys driving himself as much as others even when his material rewards are not disproportionately higher than others. He may even exhibit a certain self-righteousness about his sacrifices and dedication."

But there are also hazards in democratic administration, we are reminded. Thus the Italian social scientist Pareto described an "iron law of oligarchy," asserting that all institutions require organization, all organization requires hierarchy, and all hierarchy requires the operating rule of a minority.

"This view makes sense only when counterposed to the nonsense which interprets democracy as if it were the direct rule of the majority," Professor Hook explained. "But democracy never is the direct rule of a majority, because it never can be. All democratic life depends upon the delegation of power and all delegation must be to a minority. . . . The significant question is how this minority is selected, whether it is responsible and to whom, whether it has a monopoly of power, whether it is subject to law, whether it rests on uncoerced consent or whether the consent is elicited by the judicious use of bread, circuses, and force.

"Democracy and democratically functioning administrations are possible, but they are difficult," Professor Hook concluded. "The ultimate authority in resolving all conflicts among men is not the authority of institutions, traditions, or men, but the authority of rational method . . . when we put organizations, administrations, or bureaucracies on trial, our verdict ultimately must rest on whether they help or hurt persons."

Acclaim

THE contribution that skilled, able hospital administrators make to society is understood by administrators themselves, and by a few others. Some hospital trustees, for example, know what it means for the hospital and the community to have a wise and efficient administrator, but some still think the job can be done just as well by a retired admiral or an old friend who happens to be out of work. Some doctors understand what it takes to provide the kind of hospital service they want for their patients; others regard the hospital administrator as a natural antagonist and consider the ideal administrator is one who can be bought, sold and maneuvered. Patients are vaguely aware that there must be somebody downstairs running things but usually focus their attention on the administrator as an individual only when they want to write letters complaining about their bills. Except on rare occasions, in unusual communities, the public that is so sensitive about the hospital is totally insensitive about the man who runs it.

Because no man seeking public acclaim would expect to find it as a hospital administrator, it must be especially gratifying to hospital administrators when public acclaim seeks them out as a natural consequence of their valued contributions to community life. Last month, four hospital administrators were so sought. They were:

Ray E. Brown, superintendent of the University of Chicago Clinics, who received an honorary doctor of humanities degree from Wake Forest College, Winston-Salem, N.C.

Jack A. L. Hahn, superintendent of Methodist Hospital, Indianapolis, who was awarded an honorary doctor of laws degree by Evansville College, Evansville, Ind.

Olin E. Oeschger, general secretary of the Board of Hospitals and Homes of the Methodist Church, Chicago, who was awarded the honorary doctor of humane letters degree from Illinois Wesleyan University, Bloomington, Ill.

Bryce L. Twitty, administrator of Hillcrest Medical Center, Tulsa, Okla., who was given an honorary doctor of humanities degree by the University of Tulsa.

These awards honor the profession as well as the recipients. The citation to Dr. Brown tells why. "His influence and leadership are great contributions to the welfare of people in many walks of life," it said.

Mot Faux

GENERAL practitioners are engaged in a heated debate about the advisability of organizing an American Board of General Practice which would certify that its members met specified standards of preparation and experience. Advocates of the GP board say it is needed because hospitals increasingly require staff members to be certified and because, as one practitioner stated, "We are remiss in our obligation to young physicians entering the profession as family physicians if we do not provide them with a method to achieve the prestige and security offered by the specialty groups to those who qualify for certification."

Opponents of the proposed board view certification of GP's as unnecessary, if not humiliating. "The GP who feels certification is necessary to raise his prestige with his patients shows an extreme lack of confidence in his own ability," they say. "If certification is required to indicate that a physician has been adequately prepared, what is licensure for?"

This is a reasonable question, and, besides, there is a more pressing need for another kind of board—one which will certify that a doctor knows the English language before he starts writing for medical journals. In a symposium on the proposed GP board appearing in a recent journal, there were four references to "diplomats" of specialty boards.

A *diplomat*, doctors, is one employed or skilled in international diplomacy. One who holds a diploma from an institution of learning is a *diplomate*. Doctors who don't know the difference, whatever their other qualifications, should not have publication privileges in the journals of a learned profession.

This step-by-step account of the establishment of an intensive care unit, from planning the physical layout to selecting the staff, offers sound advice on

How to plan intensive care

Rodney J. Lamb

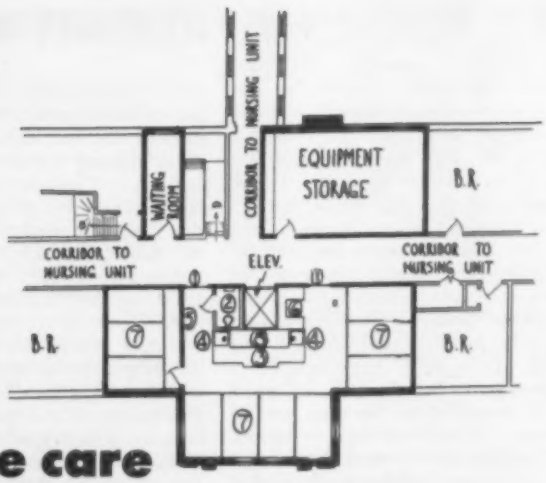


Fig. 1: Plan of intensive care unit. Numbers indicate (1) sliding doors, (2) lavatory, (3) nurses' station, (4) sinks and waste receptacles, (5) double-pane glass, (6) closet, (7) bed cubicles, (8) oxygen, suction and electricity main conduits within the unit.

A NEW concept of patient care is evolving in hospitals. At Santa Barbara Cottage Hospital we call this innovation an intensive care unit. The following is a detailed description of the unit and is in response to numerous requests we have had concerning this facility with specific analysis of its distinguishing structural and operational characteristics, and how effectively it has met the objectives for which it was created.

The facility was planned so that it would be conveniently located, practical, efficient, and esthetically pleasing. The site selected was in proximity to the greatest number of nursing departments in the hospital. Five existing hospital rooms and a former nursing station were appropriated to create the unit with a capacity of 10 beds, a waiting room for family members, and a storage room for bulky equipment, patient clothing, and reserve supplies. Four of the patient rooms were completely shelled out to provide an open area consisting of approximately 815 square feet. A plan of the area involved is shown in Figure 1. Figure 2 shows the interior of the main portion of the unit as viewed from the end of the nursing station.

Numerous features were incorporated in the unit, each of which was to contribute to the objectives mentioned. Figure 3 shows the central nursing station which provides visual control of all patients at all times, either by direct observation or by the use of the diagonally slanting mirror above the charting surface of the nursing station. Every possible convenience has been located at this nursing station to conserve space and walking distance and to make immediately accessible needed supplies and facilities. The charting surface contains the usual items found at nursing stations, such as charts, stationery supplies, telephone and dictating equipment. At each end of the nursing station are a handwashing facility and waste receptacle. Also at each end of the station is a refrigerator, each of which has a capacity of 4 cubic feet. A hot plate and an instant hot water heater have also been included in the equipment immediately adjacent to the nursing station.

To the rear and left of the nursing station are a lavatory and a bedpan washer-steamer. Anticipating the occasional ambulatory patient who still needs the type of care this unit provides, it was thought advisable to provide this lavatory facility. To the right rear of the nursing station is a storage area wherein are kept the more commonly needed items, such as intravenous solutions, administration sets, instrument sets, tracheotomy sets, and bandages. Certain medications to be listed later are stocked in the unit and are immediately accessible at the front of the nursing station.

Across the hall from the intensive care unit a former patient's room has been taken over to store the bulky items, such as oxygen tent, respirator, linens, reserve supplies, and the clothing of patients. Also across the hall a waiting room has been created from a former nursing station. This waiting room has proved particularly useful because of the limitation of space in the unit which precludes usual visiting arrangements. As might be expected, there are long and anxious waiting periods for the relatives and some facility is essential.

Throughout the unit an attempt has been made to minimize noise. Floors and wainscoting are covered with cork tile. The upper walls and ceilings are faced with fiber glass acoustical tile. The sound deadening

Rodney J. Lamb is the administrator of Santa Barbara Cottage Hospital, Santa Barbara, Calif. The intensive care unit that Mr. Lamb describes has been in operation for a year and has evoked much interest and many inquiries, he reports. Previously, Mr. Lamb served as assistant administrator of the hospital and as administrator of E. V. Cowell Memorial Hospital, Berkeley, Calif. He received his bachelor's degree from Stanford University and completed his graduate work in hospital administration at the University of California.

qualities of these two materials serve their purpose excellently. The separate room for three patients within the unit was specifically created for the occasional noisy patient such as is not uncommonly encountered with the critically ill. This room has had the same general treatment as the rest of the unit with the addition of double-pane glass along one entire wall. Not only does this glass serve the purpose of muting noise but it also provides maximum visual control from the nursing station. Double-pane glass has also been used in the door leading to this portion of the unit. Figure 4 shows the arrangement of the wall and doorway as viewed from the main part of the unit. A window air conditioner was installed in this room because of the ventilation problems anticipated when the door necessarily would be closed.

At each bedside certain facilities have been made available for instantaneous accessibility. These facilities include piped-in oxygen and suction, electrical outlets, and a collapsible shelf. Figure 5 illustrates the arrangement of this convenience panel located at each bedside.

The entire cost of constructing and equipping this intensive care unit was $25,000, the major portion of which was covered by the Ford Foundation grant. Additional support was received from a local philanthropic foundation. This cost does not include the usual nursing supplies or such items as linen and cubicle curtains. The cost per square foot of about $30 gives some indication of the costly nature of establishing such a unit in an existing structure with the extensive remodeling that was necessitated.

Major Categories of Medication Stocked in the Intensive Care Unit

Cardiac stimulants	Hormones
Cardiac rhythm regulators	Vitamins
Antihistamines	Muscle relaxants
Anticoagulants	Immunizing agents
Coagulants	Antibiotics
Analgesics	Antipyretics
Vasopressors	Laxatives
Vasodilators	Diuretics
	Sedatives
Narcotics	

FLEXIBILITY IN THE UNIT IS QUITE IMPORTANT

As nearly as possible the same operational procedures have applied to the intensive care unit as to the general nursing floors of the hospital. Following such a policy has certain obvious advantages. First, of course, is that the existing procedures have proved to be workable within this hospital. Second, the procedures are familiar to the personnel, which greatly facilitates the orientation and training of employes who work in the unit. Third, it permits the utilization of this unit for training of students in our school of nursing. We feel this type of nursing care is of distinct value to the senior students who have acquired familiarity and practice with general floor care.

Because of the specialized nature of the unit, however, there have been certain basic differences which have necessitated some adjustments in what we consider standard operation. As has been mentioned, we do not permit unrestricted visiting. The space and activity in the unit do not permit as liberal visiting policies as are in operation in the rest of the hospital. Certain of our central supply functions have been decentralized in order to make available those items needed even more promptly than we feel we can provide from our central supply service located two floors below. The commonly stocked central supply items which are located in the unit are the intravenous solutions, administration sets, instrument and tracheotomy sets, and specialized types of equipment such as an oxygen tent, masks, catheters and a respirator. Also there has been some decentralization of our pharmaceutical function to permit immediate access to the more commonly used medications.

Another distinction of the intensive care unit operational procedure is the fact that the patients are not segregated according to sex. The separation by cubicle curtains has been felt to be all that is necessary to provide separation between patients regardless of sex. The supposition has been based on the assumption that the critically ill patient generally will not be enough aware of his environment to be concerned about the possible sex difference of his neighbor.

Anticipating times when the unit would be filled to capacity and patients would be presented for admission, a procedure was formulated to assure that the facility would be made available to the patient most urgently in need of the care offered. Such a decision obviously is a medical matter and the chairman of the intensive care unit committee of the medical staff was assigned to make the decision. His word is final regarding admitting or transferring of patients and his function in this capacity has been well explained in a policy statement to all members of the medical, nursing and admitting office staffs. Complete harmony has prevailed the few times he has been called upon to decide which patients had priority need of care in the unit.

Fig. 2: Typical arrangement of special therapy beds to rear of nursing station in unit. Each bed is separated by a curtain and each has its own convenience panel.

Fig. 3: Central nursing station shows position of nurse in relation to patients. Slanting mirror over desk permits visual control of patients who are directly behind nurse.

TO MEET THE VARIATIONS IN PATIENT CENSUS AND NURSING NEEDS

The intensive care unit has accomplished a secondary but vitally important function of providing a post-anesthesia recovery facility in the hospital during the hours between 4:30 p.m. and 8 a.m. when the latter unit is not open. In effect, therefore, we have created recovery service around the clock and now have the ability to provide the same close post-operative surveillance for patients whether the surgery is performed during the scheduled operating hours or as emergency surgery after 4:30 p.m. and on week ends. This convenience has been greatly appreciated by the surgeons and anesthesiologists as well as by the nursing staff. No longer must priority care be provided to the emergency surgery cases on the general floors, possibly to the detriment of nursing care for the remainder of the patients.

Once the construction of the unit was completed there were several important matters to be undertaken to prepare for actual operation.

The most important consideration, of course, was to choose the nursing staff for the unit. It was our desire to choose a staff from among our existing personnel, since the quality of those chosen would be well known to us. We wanted nursing personnel who liked active bedside nursing, who possessed the ability to meet calmly but effectively the heavy demands and the emergency situations that were anticipated, and who were alert to observing changes in patients' condition and had the professional competence to react appropriately. The selection of personnel was undertaken by the director of nurses over a long period of time before the completion of the unit, with a careful evaluation of the merit of each individual selected whether she was a registered nurse, licensed vocational nurse, or nurse's aide.

The staffing of the unit generally is based on three persons on each shift, two of whom are registered nurses. We utilize a head nurse, staff nurses, licensed vocational nurses, and nurse's aides. The head nurse works both day and evening shifts and is counted as one of the two registered nurses on the particular shift. The third person on the day shift is a licensed vocational nurse and on the evening and night shifts a nurse's aide. One senior student nurse is also assigned to the unit five days a week, generally working three days and two evenings. Flexibility is of distinct importance, and as the census or the type of patients and their nursing needs fluctuate the staffing pattern varies, personnel being shifted from the unit to general floor care or vice versa.

We do pay all regularly assigned nursing personnel a bonus for working in the intensive care unit. The bonus amounts to $15 per month and was premised on the fact that this was a specialized type of patient care facility where particularly well qualified and astute personnel would be required.

While we have found our premise correct we do not feel that bonus pay is necessary and with our experience to date we would not, in all probability, establish a differential were we formulating policy for a new unit. Recruiting for the unit has not been enhanced by the bonus nor has it induced employes to stay who were leaving for the usual reasons. Actually the work in the unit is not any more difficult than on the general floors. While the patients in the unit do require more care the physical proximity of patients and the convenience of needed items of care have actually made the work physically less arduous than on the general floors with long corridors, separate rooms, and less conveniently located supplies and equipment. Obviously, however, we do not intend now to rescind our established policy of paying the bonus.

Once the staff members were chosen they were exposed to an intensive two days of lectures by members of the medical staff on the various medical emergency situations which were likely to be encountered in the intensive care unit. The original co-chairmen of

LECTURE SERIES

First Day

8 a.m. Spinal cord injuries, orthopedic conditions
9 a.m. Diabetic coma and hypoglycemia
10 a.m. Convulsion and post-injury unconsciousness
11 a.m. Coronary and other heart conditions
1 p.m. Chest injuries and postoperative chest and heart
2 p.m. Head injuries and brain surgery
3 p.m. Anesthesia and the airway
4 p.m. Barbituate poisoning

Second Day

8 a.m. E.N.T. and tracheotomy
9 a.m. Acute embolism
10 a.m. Cerebral hemorrhage
11 a.m. Shock, hemorrhage, and vomiting
1 p.m. Burns
2 p.m. Abdominal hemorrhages and emergencies
3 p.m. Obstetrics and gynecology
4 p.m. Genitourinary conditions

Fig. 4: Doorway and wall of separate room for noisy patients. Double-pane glass reduces sound transmission. Window also permits unobstructed view of the patients.

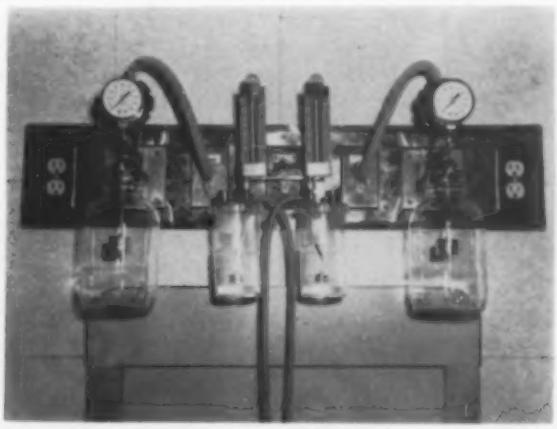


Fig. 5: Wall-mounted panel and shelf at head end of each bed contain two suction, one oxygen, and two double electric outlets. Shelf hangs just below panel.

the intensive care unit committee of the medical staff formulated the topic outline shown in the box on page 53 and assigned the various medical specialties to members of the medical staff. We felt this planned orientation and training of personnel was vitally important to the smooth initial functioning of the unit. As an interesting sidelight, we chose the unit itself as the setting for the lecture series to make the environment as natural and familiar as possible while permitting demonstration in the actual setting where the medical situations would be encountered.

A third necessary step to be taken in the preopening activities of the unit was the formulation of a policy statement to cover the intensive care unit. The administrator in consultation with the co-chairmen of the medical staff committee formulated a policy statement covering major areas we could expect to encounter in the operation of the unit. The policy statement covered such items as the purpose for the unit, procedure for admission to the unit, the availability of the unit as a recovery room for emergency surgery, staffing by the house staff, visiting regulations, and finally the rate structure.

This policy statement was sent to each member of the medical staff and became a part of the nursing policy book. This statement has helped materially in clarifying the purpose of the unit and permitting its operation within the framework of consistent, clearly defined, and well understood policy.

Another important part of the preopening activity, we felt, was to obtain adequate publicity for the unit, as concerned both the medical staff and the community at large. The week before the opening of the unit the local press provided the services of a feature writer and a photographer and the result was an excellent job of portraying the unit both in word and in picture. Widespread interest and awareness were evoked as a result of this publicity.

We also held open house for all members of the hospital and medical staffs. The response to the open house was most gratifying as many members of our medical staff and nearly all members of the hospital staff, both professional and nonprofessional, toured the unit and became basically familiar with its purposes and operation.

The final detail to be worked out was the setting of an equitable rate. This was difficult, since there was no precedent from which to work. In brief, we compared the anticipated staffing hours per patient per day in the unit to those recorded for the general nursing floors. This ratio was then applied to the existing ward rate of the hospital and the resultant figure established as the intensive care unit rate. Subsequent detailed cost studies have shown that the rate selected was very realistic.

Statistics for the first year of operation give some indication of the categories of patients cared for in the unit, the trend of utilization, and the nursing staff required on a comparative basis.

Chart 1 shows that the greatest number of patients admitted to the unit have been on the service of general surgery (36.3 per cent). Following in order are: medicine (25.3 per cent), neurosurgery (12.7 per cent), thoracic surgery (9.1 per cent), orthopedic surgery (8.8 per cent), genitourinary surgery (6.5 per cent), and ophthalmic surgery (1.3 per cent). The total number of patients admitted was 308. An additional 199 patients were cared for in the unit as postanesthesia patients during hours when the recovery room was closed.

Chart 2 shows the average per cent of occupancy by months for the first year of operation. The lowest month was the first (26 per cent), and the highest, the last of the year (54 per cent).

Chart 3 offers vivid proof of the relative intensity of nursing care provided to patients in the intensive care unit. Nursing hours per patient day for the intensive care unit range from 2.8 to 6.2 times as great as for the average of other areas of the hospital. The expected relationship exists between hours of care per patient day and per cent of occupancy, with generally the months of highest occupancy showing the lowest number of hours of care per patient day and vice versa.

CHART 1

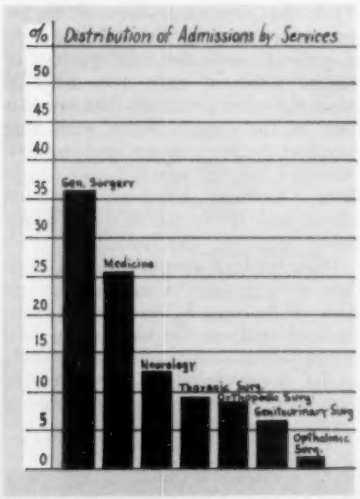


Chart 1 shows that the greatest number of patients admitted to the unit have been on general surgery service.

EVALUATION

A general conclusion or opinion of the unit is that it has been a highly successful venture and one which offers distinct possibilities for gaining in popularity and perhaps even eventually becoming as prevalent as recovery rooms have become in general hospitals.

The expressions individually and collectively from the people concerned have been overwhelmingly in favor of the intensive care unit. Medical staff members feel their patients in critical condition who are admitted to the unit are receiving consistently superior care. The nursing staff finds that the load on the regular nursing floors has been considerably relieved by concentrating the critically ill. The unit has provided an excellent caliber of care to those patients who are most urgently in need of this care. Clearly, therefore, our expectations for the unit have been fully realized. The response of patients and their families has been enthusiastically in support of the unit and the community in general has also shown great interest.

It would, of course, be unrealistic to leave the impression that there have not been problems in the operation of the unit. Of those that have arisen some have been confronted and

CHART 2

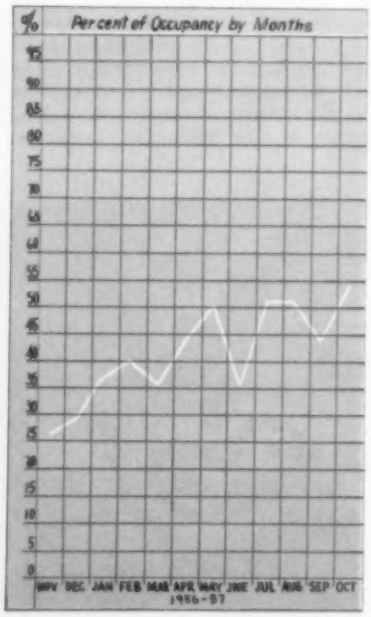


Chart 2 shows ups and downs of occupancy. The first month was 26 per cent; the last, and highest, was 54 per cent.

solved and some of these problems have yet to be solved.

There was initial disparagement by some members of the medical staff who frankly stated that the unit was not needed and they would not use it for their patients. Some may still feel that way but it is interesting to note that some of those who expressed an initial disinterest are now among the most consistent users of the unit for their patients.

We have frequently been asked whether the fact that we do not separate the sexes has led to any problem. The few instances where this has been a problem are due entirely to the fact that the patients have progressed from the critical stage of their illness but through their own or their physicians' preference have remained in the unit. They then become more aware of their surroundings and are more concerned that their neighbor may not be of the same sex. The same may be said for the patient who normally would be cared for in a private room. During the critical phases of treatment there is of course no problem; when this same patient stays in the unit beyond the critical phase then there may be some problems because he is in a ward facility. Usually, the family is the more vocal about expressing both of these complaints. It is interesting at the same time to note that even when the physician has recommended discharge from the unit in many cases the patient or the family has resisted strongly any attempts to move the patient from the unit. When the unit has been occupied to capacity this unwillingness to leave has even made it necessary for the intensive care unit committee chairman to use his authority to transfer a patient from the unit to permit one more in need of the care to be admitted.

Another problem which has presented itself, and which only exists because of the very nature of the unit, has been the ventilation. Because four rooms were used to create the unit and, as a result, wall-door-window relationships have no longer retained their integrity, the moving of air is a problem. Dead air spaces are created which natural ventilation is inadequate to correct. The air conditioning unit in the soundproof room has worked very well. Ventilating equipment has been installed in the large room which, in essence, is an exhaust system. The results are still not totally satisfactory, but it is anticipated that a satisfactory mechanical system will be installed which will provide the necessary air exchange.

We initially experienced some concern over the low occupancy of the unit. While we fully anticipated that the new unit would have a period of initial low use, we perhaps were impatient to see it utilized as fully as possible to justify our hopes and the large financial outlay required for its creation. At the present time our optimism seems well justified as the average occupancy of the unit has continued to improve month by month. Obviously, the intensive care unit is a specialized facility and, as such, the same fluctuating census experienced in other specialized units, such as obstetrics and pediatrics, can be anticipated.

We do feel confident that the unit is large enough not only to serve our present bed capacity but also to care for additional expansion which is now being contemplated. We feel the intensive care unit will grow in importance as the hospital increases in size and we were justified in providing not only for our present needs but also for those in the immediate future.

Our most vivid proof of the popularity of the unit with the medical and nursing staffs was evidenced several months after the unit was opened and our nursing shortage was acute. As a result, one department of the hospital was closed down and many doctors desiring to admit patients had to defer admission or use another hospital. The usual problems with such disappointments resulted and considerable thought was given to a solution. While we realized that the intensive care unit was valuable, we also realized it required considerably more nursing personnel to staff than would the same number of beds on general floor care. We felt that if we were to close down the intensive care unit we could open the department that had been closed and which contained approximately twice as many beds as did the intensive care unit. This suggested solution was broached to the medical and nursing staffs. The nursing staff's immediate response was that the situation would not be helped because the critically ill then being cared for in the unit would have to be cared for on the general floors, thus aggravating the already serious shortage of nurses. The medical staff approached the problem somewhat differently. My telephone was kept quite busy with urgent telephone calls from leading members of the medical staff urging me not to close the unit. Any reservations we had as to the regard which the medical staff felt for the unit were dispelled. It is interesting also to note that the doctors' discontent at not being able to admit patients to the hospital virtually disappeared.

In summation, we are pleased with the physical arrangement and the organizational procedures which originally were conceived for our intensive care unit. Virtually no alterations of procedure have been necessary and only minor pieces of equipment have been added which were not initially anticipated. Much credit must be given to those members of the medical and hospital staffs who originally conceived and planned the intensive care unit. #

CHART 3

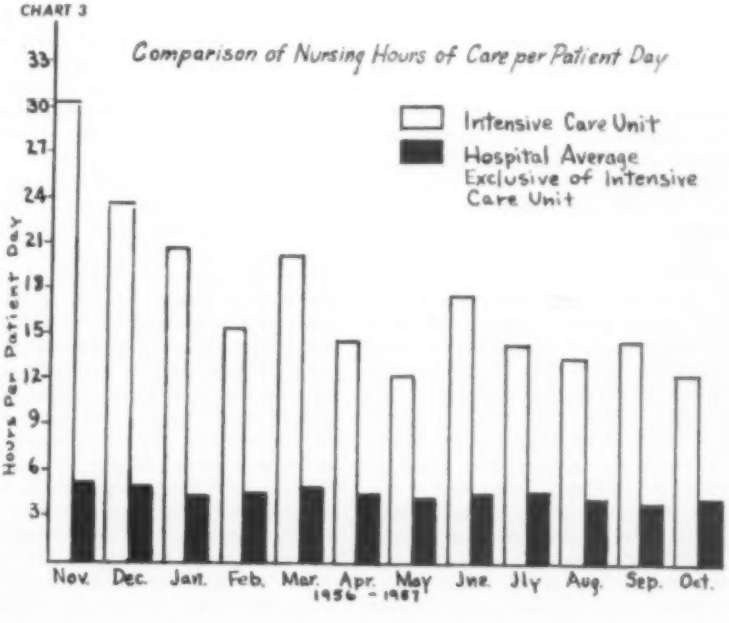


Chart 3 offers graphic evidence of the intensity of nursing care given in the intensive care unit as compared with the amount given in other areas.

Common Problems in Hospital Accreditation

In this free-wheeling discussion of what accreditation is, what it is intended to do, how it works, and why it is needed, the director of the Joint Commission points out that, basically, accreditation is a method of making certain that hospitals and everyone who is connected with them live up to their responsibilities to patients and the public

Kenneth B. Babcock, M.D.

THE Joint Commission on Accreditation of Hospitals does not change its standards overnight. Our by-laws say that standards must be gone over by the standards committee and then presented at the next meeting to the board of commissioners. A change cannot be voted on at that time; it must wait until the next board meeting. So there is a thinking period on every change of standards.

For example, hospitals are losing money on obstetrical cases in a good many instances. The medical and surgical departments are overflowing, but the obstetrical departments are only 20 per cent, 30 per cent, or 40 per cent occupied, and yet the ruling is that the OB department must be an isolated or segregrated service.

We have had a committee working on this problem for a year. The vote so far from the medical schools and the public health group, and from prominent obstetricians and gynecologists, has been 75 per cent in favor of permitting clean gynecological and surgical cases on the obstetrical floor. I would not be surprised if within three to six months that standard might be adopted. But it isn't a rule yet! And don't do it in anticipation, because the control measures are now being written and have to be worked out, and, believe me, if this procedure is going to be allowed, you will control it!

We have six states in which the law says obstetrical cases must be segregated; in those instances, of course, no matter what ruling the Joint Commission makes, you cannot abrogate the law, and so you must keep the segregation if you're in one of those states.

Many hospital administrators have come to us and said: "What about internal medicine? Your rules—35 years with the American College of Surgeons and now your present rules—have to do mostly with surgeons! The tissue committee is tangible; it's got something to sink its teeth in. But tell us about the departments of internal medicine. What criteria are there for departments of internal medicine?"

There aren't any. The American College of Physicians was asked some three years ago to try to draw up such criteria. They met for a year and worked on this project, and now they have a three-year grant to study it.

What criteria can you have for departments of internal medicine, which include 40 per cent of hospital patients? It is difficult to put quantitative measures on quality, but it looks now as though the study committee is going to come up with about 50 recommendations. If your hospital can comply with about 30 of those 50, they figure that the department of medicine is being well run.

One of the 50 is bound to be the autopsy rate. In our statistics throughout the country, the better hospitals are those with the higher autopsy rates. One teaching hospital that had a very low autopsy rate gave us the usual excuse: "We have the wrong type of population; it's all old people, and their religion is such that it can't be done!" Then one of the doctors said: "Let's get a staff fund and tell the interns and residents that for every post they get, they'll get $5." That hospital now has a 60 per cent autopsy rate.

The view that it is harder for small hospitals to become accredited is all wrong, in my opinion. I think the hardest hospitals to accredit are the big ones, because they have 10 times more problems than the little ones, and it's all a matter of relativity and proportion. I will assure you that the Joint Commission will never establish one set of standards for large hospitals and another set of standards for small hospitals. Once we do this, we have acknowledged to the American public that there are two kinds of quality care. I'm sure the small hospitals do not want to feel that they're the low man on the totem pole, and that their services are inferior to those of the big hospitals. Quality comes from dedicated people; if you know your limitations and live within them, you are going to be all right.

I was commanding officer of a field hospital in Italy. We were never outside of tents. Often our operating room tables were two wooden sawhorses with a canvas stretcher set across them. We gave good care! Good care comes from dedicated doctors, nurses and hospital personnel. It's nice to have up-to-date equipment, but still, it is individuals who give care.

Why do nonaccreditations occur? In 87 of the first 100 hospitals that we nonaccredited during the last year, we found lack of medical staff organization; lack of teamwork; lack of review because of disorganization. The doctors were saying: "Let your conscience be your guide. You go your way and I'll go mine."

I'm a doctor, and I'm proud of it. I think 95 per cent of all doctors are ethical and moral. But there are 5 per cent who do need supervision and rules and regulations, just as we have to have traffic laws because some people break them.

Dr. Babcock is director of the Joint Commission on Accreditation of Hospitals, Chicago.

Condensed from the recording of a talk presented at the accreditation institute of the Texas Hospital Association, Austin, 1958.

Doctors are trained and brought up as individuals; for some it's pretty hard to act as a team, as the Joint Commission requires. And yet teamwork and medical staff organization and review are so important for the common good of all that in some instances we have to give and be elastic.

Medical staff organization is important! Hospitals that don't have it are in trouble all over the country. There is one 400 bed hospital in the West with 875 men on the staff—less than half a bed per doctor! You don't get a case in that hospital unless you give the room clerk six nylon stockings! I've never known such a cutthroat institution! Where is the organization? Where is the loyalty? Where are the thought and the integrity behind that institution?

We said: "Let's analyze this staff." There were 25 doctors on the "active staff" who had not brought a case into the hospital in five years! More than 200 doctors on the courtesy staff who hadn't brought a case into the hospital in five years! What an awful amount of window dressing! And no effort toward organization!

Frequently we are asked: "What about doctors on the medical staff being on the board of trustees?" The Joint Commission does not agree with the theory that doctors must be on the board, or that they must not be. The Commission says to all hospitals, "You will have liaison or rapport of some sort—and it will be good—between your board and your medical staff." Whether it is in the form of a joint conference committee, whether it is having staff officers sit *ex officio* at all board meetings, as many do, or whether it is a combination, with a joint conference committee and the chief of staff or the vice chief of staff present at board meetings, is not important. We say only that there must be liaison in some form or other.

I will not buy for a minute the position that there must be a doctor on the board. Your board of trustees should be a good cross-section of the community. If you think a doctor can be a member of that cross-section and truly represent the medical staff and his profession, put him on! But don't put him on just because he has the label "M.D." We will not criticize the hospital having a board with an M.D. on it, or one having a board without an M.D. That is your choice. But you must have rules, and you must have consultations. We nonaccredited one hospital where one of the medical care organizations had refused to pay the hospital. They said: "You're doing unjustified work," and they pointed to 380 hysterectomies. They said: "Over 80 per cent of those hysterectomies are on women of childbearing age, and they're unjustified—at least judging from the pathological report."

Three years later, we accredited this hospital. In 1956, the hospital had just 38 hysterectomies. From 380 to 38!

That is an extreme case. Hospital medical staffs that are living up to their responsibilities could not let something like this go on!

The second commonest weakness is poor medical records. Sloppy records usually go along with poor organization.

A hospital in New England came in to us and said: "You can't nonaccredit us! We have two men come up from Harvard every month for staff meetings in which they go over cases! We have better medical education here in our small hospital of 60 beds than they have in many teaching hospitals!"

We said: "Here are your own records, filled out by your own hospital superintendent. You had 1700 cases at this hospital last year, and you've got 1100 undictated charts. How can you do any worth-while review when over half of your cases aren't even on paper yet?"

At another hospital we studied, a woman was operated on in 1955 for a total hysterectomy; to us, that means "complete removal." But her 1956 chart was stapled to the 1955 chart, and she had delivered a full-term baby —the following year!

You know when a patient is only in the hospital 48 hours you may use a short form for the record. We try to make charts so they're not a chore. And one case I remember was a typical short form: "Admitting diagnosis: Piles. Operating diagnosis: Piles. Discharge diagnosis: Piles." End of chart.

It wasn't laughable in this case, because pasted on that chart was the pathological report. The tissue had been sent to the university and the tissue report pasted on that chart was: "Adenocarcinoma, Grade II." The medical librarian hadn't called it to the attention of the doctor, and the doctor was too busy or too lazy to look at it, and so somebody died.

In three and a half years at the Joint Commission we have found nine hospitals that applied for accreditation, which had yet to write their first history and physical at the time of our survey. Nothing but doctors' orders and nurses' notes on the charts!

When you give a doctor the privilege to do surgery, you should not ask, "Has he got his board?" alone, or "Is he a fellow of the College of Surgeons?" Those are excellent standards and we recommend them. But the question is far more basic than that. Suppose this man is saying he wants to do appendectomies and hernias; your credentials committee should ask the following question: "Would I allow this man to do an appendectomy or a hernia on me?" If the answer is "No," then he shouldn't be allowed to do it on anybody else—whether he has his board certification or whether he's a fellow of the College. On the

WHEN SHOULD A "STOP ORDER" BE APPLIED?

Question: Please comment on the requirement for stop orders on dangerous drugs. If the medical staff carefully considers the requirement and then elects to have each physician personally assume the responsibility, is this a violation of Joint Commission requirements?

Dr. Babcock: The Joint Commission on Accreditation of Hospitals is not telling any doctor that at the end of 48 hours or 72 hours he has got to repeat a prescription. We would not criticize a hospital or a doctor if we found that penicillin, say, was ordered for 100 days. This is a definite order, and we are not going to put our judgment against the doctor's. That is not an uncommon order in tuberculosis sanitariums, for example, on streptomycin. It's ordered for three months. We have no criticism of that.

Our criticism is on open-ended orders. Your hospital must have control measures on open-ended orders, the order which says: streptomycin, or penicillin, or morphine: "Q-4 hours." Now when is that up? Two days from now? Two hundred days from now? Has the doctor forgotten it? It is this P.R.N. order, this "as necessary" order, without any stop on it, that is dangerous for the patient. The order should have a time limitation set on it by the medical staff and carried out by the nursing staff. What are dangerous drugs? We think that the dangerous drugs are the antibiotics, the anticoagulants, the narcotics, and the analgesics.

other hand, there are thousands of excellent general practitioners who have had good preceptorship and do excellent surgery, and your credentials committee should assess the man as an individual, taking into consideration all facets of his professional training and experience. Board membership isn't any different from an accreditation certificate; it's a certificate saying the man has passed a certain test. It doesn't say that he's moral, or ethical, or anything else. The complete answer is not there, and so you must put your man on probation and watch him.

Recently a question has been asked us about the possibility that complete records, such as tissue committee records and others, may be used against the hospital in a lawsuit. The answer is that if you have a good, sound chart, with the documented evidence, you do *not* have to worry about a lawsuit. But you can't have an inferior chart or record and then expect not to be taken to pieces when you go to court.

Many hospital administrators have said to the commission, "I want accreditation, but my staff isn't interested. How can I get it done?"

The first thing is to get over that defeatist attitude! You can always find one good man on the staff, a key man, who will work with you. Then you've got to propagandize. Tell about other hospitals that are accredited, and what accreditation means. Communicate with the doctors. Let them know. I could take you to two hospitals where the doctors sat back on their heels and said: "No. We're satisfied the way it is." Then I talked to members of the ladies auxiliaries in Atlantic City, and they went home with blood in their eyes. The ladies auxiliaries talked to their doctors, and in two years they got accredited!

It can be done. The administrator is a catalyst, a coordinator, and perhaps at times a "gadfly."

Unfortunately, the administrator also may be the whipping boy. I'm sorry to say that when a hospital is nonaccredited it's usually the administrator who loses his job! It's wrong, but we've known it to happen repeatedly. It should not be that way, because accreditation or quality of care for the patient comes from the medical staff, the board of trustees, and administration all living up to their responsibilities; no one group can do it alone.

What are you doing about sanitation? Air conditioning often has a long way to go. We've found several hospitals in which they are recirculating air and blowing germs out into the operating room and other treatment rooms. In one hospital we went into, the main intake of air was from a corridor outside the pathological laboratory; they were blowing staph and strep into the operating rooms!

One of our recommendations is going to be that the hospitals of the United States will add one more mandatory committee to their organization, and that will be a committee on infection. On that committee you will put doctors, you will put nurses, you will put housekeepers, you will put administrators, and you will put public health people, because they're all involved. One hospital had six months of impetigo in the nursery. They said: "We've done the walls five times; we've done the blankets; we've done everything." So my man went through, and he looked into the nursery. What did he see? He saw a nursing attendant in there with a very bad acne!

She had no right to be there! It isn't the walls, and it isn't the catgut, that are responsible for most of these infections. It's human beings with furuncles, or hangnails that are infected, going into the operating rooms. It's the operating room nurse or doctor with a slight fever—"Oh, I've got the flu, but I'll be all right." #

Disaster Plan Functions Well in Wisconsin Tornado; Information Service Is Only Flaw

EAU CLAIRE, WIS.—When a hard-driving tornado struck central Wisconsin the evening of June 4, the Luther Hospital here (225 beds) was prepared for the worst. The hospital had a detailed, written disaster plan. "The plan functioned," said N. E. Hanshus, administrator.

During the evening, 43 casualties were admitted as inpatients—most of them suffering from fractures, lacerations and abrasions. In addition, a number of patients with minor injuries were treated in the outpatient department and then discharged to their homes.

Here is the disaster story, as told by Kenneth D. Hanson, assistant administrator:

"At approximately 7 p.m. I heard the announcement on the radio that there were tornado warnings in this area and that one tornado had struck at Woodville—30 miles away. I called the Luther Hospital switchboard, the information desk, and the night supervisor, informing them that there was a possibility of a disaster and suggesting that they go over the disaster plan to brush up on their instructions.

"At 8:15 p.m. we received a call that 20 patients were being sent in from a tornado in Colfax, Wis., a few miles west of us. The night supervisor then ordered the disaster plan into effect. When I arrived at the hospital at 8:30 p.m. the first victims were just coming to the ambulance entrance."

Major steps in handling disaster victims according to plan were then described by Mr. Hanson as follows:

1. Off-duty personnel had been called and were arriving on the scene.

2. Student nurses from the dormitory were called to report to the ambulance entrance and assigned to various floors and duties in the emergency entrance area—tagging patients, cleaning up patients, and taking patients to their rooms.

3. An adequate number of orderlies were called to handle the listing, along with volunteers.

4. Mattresses were brought up from the basement and placed in the corridors, library and staff conference room for patients, until they could be transferred to hospital rooms.

5. Extra beds were brought up from the basement, along with beds that were pulled out of the nurses' home and set up in the halls.

6. Maternity patients were transferred out of a six-bed ward into other maternity beds, and the ward was taken over for disaster victims.

7. Surgery for the following morning was canceled, and 10 patients who had been admitted for elective surgery were sent home.

8. Patients were examined in the emergency room, the cast room, the eye room, and the surgeons' lounge, and then sent to their rooms.

Most patients were admitted before 9:45 p.m., Mr. Hanson reported, although they continued to come one or two at a time until after midnight, and surgery was busy until 2:30 a.m.

"The kitchen was opened and refreshments were provided for patients and employes," he continued. "Also the laundry was opened and operated from 10 p.m. until 2 a.m., providing us with a good supply of clean linen in the morning. The switchboard was kept open all night and all calls from relatives and the press were referred to the record librarian.

"The only real problem we had was obtaining an accurate list of casualties and their condition for the many calls from relatives and the press. It wasn't until after midnight that the list was fairly accurate." #

(See page 133 for other news of Wisconsin tornado.)

Since hospitalization often represents their first night away from home alone, children particularly are the beneficiaries of recreation program.

Recreation program is helpful to patients

Howard Weinberg
Sheldon King

HOSPITAL staffs, busy with medical therapy, cannot be expected to plan the recreational and social needs of patients. Yet orthopedic, pediatric or long-term patients, as well as persons waiting for special laboratory tests and procedures, have a need for diversion. At Mount Sinai Hospital, New York, an extensive program of leisure time activities has been provided since 1952.

A recreation department is now staffed with a director and two assistants, plus many volunteer workers. A student recreation worker has been assigned to the department by a university graduate program for field training. The director is responsible for organizing the program, and reports to an assistant director of the hospital. Since recreation must be carried out with a minimum of disturbance to medical and administrative schedules and the physical plant, the program has been divided into three sections, according to patient need. One is designed for bedridden patients, and activities are arranged on an individual basis. Out-of-ward activities are for those who are ambulatory or who can be absent from the ward for a period of time. Special services include programs in the psychiatry division, the outpatient department, and the respirator center.

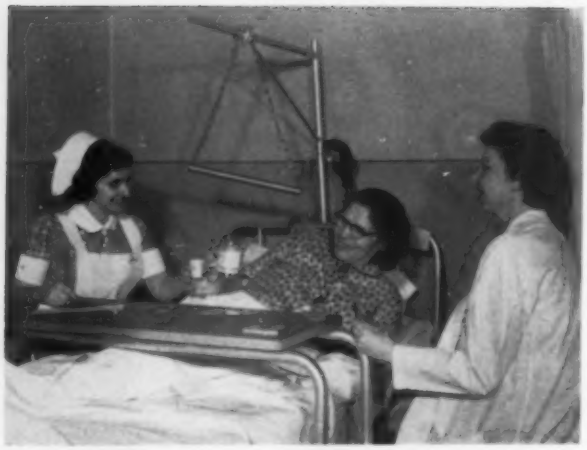
During 1956, the department provided more than 4000 individual service calls and more than 50,000 group activity hours. Recreation materials, such as arts and crafts supplies, games, books and magazines, have been donated by local merchants, philanthropic groups, and others in the community. The purpose of the program is diversion, rather than therapy as such, although relief of tension and boredom may produce a therapeutic advantage, officials say. With an improvement in patient morale, complaints of minor discomforts and consequent demands on staff members also diminish.

(For additional pictures and text, see following pages.)

Mr. Weinberg is assistant director and Mr. King is administrative resident at Mount Sinai Hospital, New York.

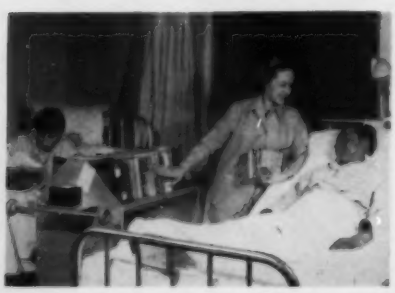
Below: Volunteers are assigned to program by director of volunteers and then undergo a period of formal training.

Right: Staff members work with volunteers during the eight-week training period.



Crafts are among the activities found entertaining by the bedridden patients.

A library service, recorded music, movies and TV are provided for the bedridden.



Eight Weeks of Formal and On-Job Training Is Given to the Volunteers

IN TERMS of actual hours of service to patients, the core of Mount Sinai's recreation program is the volunteer staff. An average of 60 volunteers provide about 400 hours of service per month, divided almost equally between adults' and children's recreational activities. The director of volunteers assigns persons to the department, and a formal training program is then conducted by the recreation director to teach specific skills and proper approach, as well as information about hospital procedures. Members of the staff, including residents in medicine, orthopedics and psychiatry, and representatives from nursing and social service, help to plan the orientation program. During an eight-week period of formal and on-the-job training, the new volunteer is observed and supervised by a professional recreation worker. Among the activities provided for bedridden patients are arts and crafts, movies and television, entertainment by special groups, a library service, and recorded music. The recreation program was undertaken by the hospital at the urging of the women's auxiliary board.

Sixty volunteers provide 400 hours of service per month, divided equally between activities for children and for adults.

Left: The patient's physician serves in advisory capacity in prescribing the range of recreation to be permitted his patient. Recreation events are scheduled to avoid conflicts with medical treatment.

Volunteers Organize Parties That Get the Patient Out of His Room

THE out-of-ward activities program is designed to remove the restrictions imposed on a patient by confinement to a room or floor during long periods of hospitalization. Several areas, such as dayrooms, patios and conference rooms, have been designated for group activities during the early evening hours when crafts are impractical. These activities include birthday parties, community singing, discussion clubs, and picnics within the hospital. Special programs for Christmas, Thanksgiving, Halloween, and other holidays are provided. Arrangements for transportation are made prior to each event, with the ward physician giving consent for patients to participate. Volunteer workers accompany ambulatory patients to the program; patients in wheel chairs and on stretchers are moved by hospital orderlies. The physician serves in an advisory capacity in prescribing the range of recreation permitted for each patient, or he may make a direct referral of patients for whom recreation can aid social readjustment or postoperative recovery.

(*Continued on Page* 62)

The out-of-ward activities program includes lectures when this is possible.

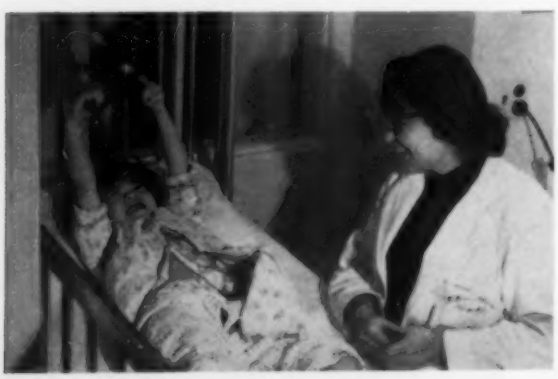
Dayrooms, patios and conference rooms are also used for out-of-ward sessions.

Special programs are arranged for the ambulatory patients at Christmas, Thanksgiving, Halloween and other holidays.

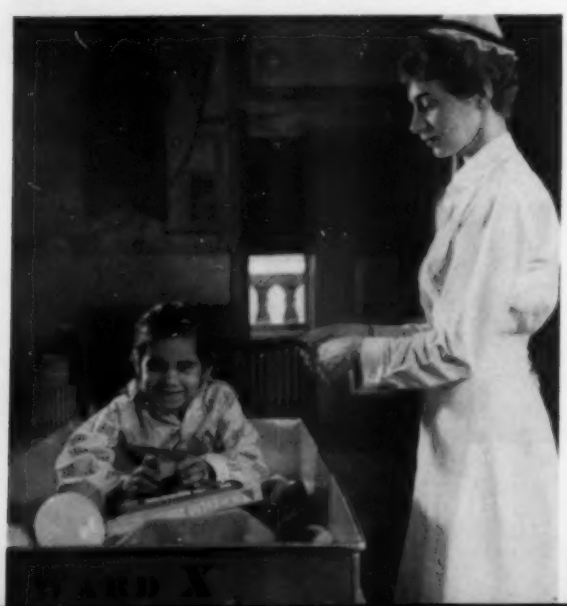
Left: Recreation is planned to relieve tension of waiting in outpatient department.

Below: Opportunity to work with community's children found a warm response. Group activities help the young patient.

Below: The simplest plaything can bring ecstasy to a child, relieving the fretful monotony of an otherwise trying period.



Below: Children are easier to handle when they have the diversion of a toy. Birthday parties are another feature.



What Might Be a Trying Time for a Child Is Made Much Pleasanter

THE children's recreation program provides an appealing variety of fun and diversion for pediatric patients. What might be a trying period for a child is made pleasanter by community singing, varied arts and crafts, puppetry, group games, quiet games, and birthday parties. The opportunity to work with the community's children has found a warm response, with successful recruitment of volunteer workers.

Special services in the recreation department include a psychiatric program, closely supervised by a staff psychiatrist. Dinner parties prepared by patients, book discussion clubs, dramatic readings, square dances, movies and television are provided. Patients have participated in a newspaper dealing with activities of the psychiatric ward. Another service is conducted on the ward for treating polio patients with respiratory difficulties. This was a challenge to the department, since these patients require special and constant medical supervision. Programs such as movies and a newspaper have been devised for them.

To relieve the tension of long waiting periods in the outpatient department, the hospital began a one-year study, under a grant from the United Hospital Fund of New York. Arts and crafts, games such as checkers and puzzles, and painting and coloring for children were introduced. Movies were used for diversion as well as health education. The activities were most successful. Complaints about waiting, and accompanying irritation, dropped markedly. Pressure on the busy clinic staff was reduced. Here, too, it was shown that a planned recreation program that considers facilities, needs and limitations can serve a useful purpose in satisfying a patient group.

What It Takes to Be a Good Supervisor

A supervisor has seven major functions: to decide where he fits into the organization; to establish his objectives; to organize his work; to train and direct his employes; to coordinate with other departments; to evaluate his own and subordinates' work, and to report to management

Richard T. Viguers

IT IS generally agreed, both in hospitals and in industry, that the most critical shortage today is not manpower but "intelligent management of men." Certainly we are short of personnel in hospitals and we all have many vacancies on our staffs, but a greater shortage exists in supervisory personnel. This is a shortage not so much of numbers as of talent. We need to build up a group of supervisors who are able to get more and better work from subordinates. It may be impossible to get 10 per cent more workers to add to a department in our hospital, but it is not impossible to improve supervision to get 10 per cent more production from the workers we now have.

Department heads and supervisors in hospitals represent hospital management to workers. The supervisor is "the boss." He represents management's policies, management's aims, and management's prerogatives. Consequently, everything the supervisor does reflects upon the management. It reflects its attitudes, its interest, or lack of interest.

Since the supervisor is management's representative, much of the responsibility for the worker's attitude toward the hospital and its patients rests upon the supervisor's shoulders. If his conception of management policies is faulty, the attitude of the workers toward management is likely to be faulty. If the supervisor is poorly trained or has received inadequate training in handling employes, the workers themselves will soon give evidence of this fact in their attitude toward the hospital and the patient. If the supervisor does not know how to instruct his workers in their duties, this will reveal itself in the quality of services rendered.

With employes looking to their supervisors for information on all phases of hospital administration and with management looking to supervisors to carry out a host of duties and responsibilities, it is vitally important that these supervisors have a background of knowledge to call upon to exert leadership toward a common goal.

The most important and valuable assets of any hospital are the employes —the people who care for the patients. Supervisors are often impressed with the expensive equipment they are responsible for, *i.e.* x-ray units, electroencephalographic equipment, accounting machines, laundries and boilers, but more important and more expensive are the men and women who are the hospital employes. It is their talents, skills, experience and hard work that really make the hospital. The care and development of this human resource is a primary responsibility of a supervisor.

To get more efficient production is only part of our aim. Supervisors should contribute to and facilitate the development of a happy group of workers—men and women who are doing satisfying and rewarding work and enjoying it.

This satisfaction to the workers is not merely a means of achieving more efficient production, but is an end in itself. While our primary responsibility is to the patient, we also have a responsibility to the worker. The worker spends most of his life working, and it should be as interesting and rewarding as it can be made. We need to think in terms of the needs of the worker as well as the needs of the patient.

The essence of supervision can be stated in two simple phrases: "Be a good boss" and "Develop a team."

Being a good boss means being a help to the worker, being supportive rather than threatening. If the worker immediately goes on the defensive, makes excuses, or otherwise defends his action when his supervisor approaches, then the supervisor is not a good boss. But if the worker feels that the supervisor is going to support him and help him, then the supervisor is a good boss.

Developing a team of the workers

Richard T. Viguers has been administrator of the New England Center Hospital in Boston for 10 years. He has both a B.S. and a law degree. Utilizing experience as a foreign correspondent in China, he served with the Chinese army in India in World War II and later was executive officer of a military hospital in Texas. He was president of the New England Hospital Assembly, a trustee of the Massachusetts Hospital Association, and is a member of the council on administrative practice of the A.H.A. He is a fellow of the A.P.H.A. and a member of the Royal Society of Health.

means a happier, more productive group. It means making every worker feel he is a member of a closely knit and effectively functioning group with good mutual relationships and communication and high performance goals. Traditionally in hospitals there is low turnover and absenteeism and a high standard of performance in the central supply service. This is, in large part, the result of the nature of the work and the development of a small group that works closely together as a team.

The first thing a supervisor should do is to determine his place in the organization. The supervisor must know to whom he reports and he must know the persons who are responsible to him. This seems like a simple thing, but it is not always clear, and without a knowledge of the organizational pattern, good supervision is made extremely difficult.

Knowing the organizational structure does not merely mean knowing the lines and boxes drawn on the organization chart. It means knowing who actually has the authority and gives the orders. To a large extent it comes down to the matter of communication. The supervisor must know how he gets information and how he passes it on, and how he gets necessary support, coordination, supplies and assistance from other departments.

In hospitals where we have orders originating from at least two areas—administration and medical staff—there is a special problem in explaining just how the organization functions.* But this is no reason for ignoring the matter; it only makes it more important to make the actual situation as clear as possible.

We can point out that orders relating to the direct care of a patient come from the doctor. Whether the patient is to be given cortisone or aspirin is determined by the doctor. What laboratory examinations are to be given, whether the patient is to stay in bed, what sort of a modified diet he should have—all these are the direct responsibility of the physician, and he will make the decisions and give the necessary orders to hospital personnel.

On the other hand, orders regarding general policy and financial matters come from the administrator on the general or specific authority of the trustees of the hospital. These orders come through the department heads to supervisors and then to the employes working under those supervisors. Who should be employed and how much they will be paid is determined by the administrative line of authority. Which patients will pay and how much they will pay, what types of patients will not be admitted, whether all tissue removed in surgery will be sent to the pathology department, what sort of a medical record will be kept, standards of cleanliness, whether smoking will be permitted in the operating room—these are examples of policy matters in which the orders come from the administration.

General instructions will not cover every situation, and only after he has worked in a hospital for some time and learned its mores will an employe be able to determine correctly who gives the orders in every situation. But it will be helpful for an employe to have some general understanding of the dual lines of authority in a hospital.

A supervisor should look to his superior for the necessary information and guidance in learning his position in the organization but, if this is not forthcoming, then the supervisor must take the responsibility to go to his superior and find out the person or persons to whom he is responsible and the workers who are responsible to him.

DETERMINE OBJECTIVES

The second important function of a supervisor is to determine what he is expected to do. What are his objectives? What does management want him to produce? The supervisor should understand the general objectives of the hospital as well as his own general objectives. Then he must establish specific objectives for his own department or section.

This sounds simple and obvious and there are always objectives either formally or informally established but often they are the wrong objectives and the objectives of the supervisor are not consistent with those of management.

I can think of a dietitian who was about to be discharged for serving inferior meals to hospital personnel. It was only at a final conference with the administrator that the dietitian stated that she thought the budget had to be kept to a certain low figure, while the administrator said that he had never intended that the budget be kept at such a figure and that he wanted good meals served even if it meant an increase in cost.

The third function of the supervisor is to organize. This involves a conscious effort preceding the actual performance of work. It means planning the supervisor's own job and it means planning what each one of the workers is going to do. Organizing includes the specific tasks of job analysis, staffing, work scheduling, and delegation of authority and responsibility.

A common failure of supervisors at all levels is their inability to delegate. The supervisor must realize that his pattern of operation is to work through others and when he spends his time doing the work directly he usually does not have time to carry out his supervisory functions. Of course, this does not mean that the supervisor never does any of the immediately productive work. It merely means that as a supervisor he can accomplish most by supervising and not by working directly, and in order to accomplish this he must delegate authority and responsibility to others. This takes conscious planning and a careful review by the supervisor of his own activities so that he does have time to supervise and delegates to the full capacity of those working under him. Too many supervisors use their hands and feet instead of their heads.

The next function of the supervisor is to train. A supervisor is a teacher and a major part of his activities are concerned with teaching. This teaching goes on all the time. It is not only in formal training programs, for hospitals actually have few of these, it is the informal day-to-day activity that is a major training effort. A worker is learning every day and all day something about his job. He is either learning to do the job badly or learning to do it well and it is up to the supervisor to see that he is learning to do it well. A supervisor is selected partly because of his special knowledge, skill and experience, and these talents must be passed on to the worker. It begins with the orientation of the new worker and carries on with the explanation of his job and how he is to do this job.

While a formal training program is not essential for all jobs, a conscious training effort or some sort of informal indoctrination is certainly necessary. This must be followed up with repeated evaluations of the job, corrections of mistakes, and further training so that the job can be done better.

Good training is not merely the imparting of information from the top down but is the involvement of the worker in this training process. It has been well said that improvement of workers is not so much a supervisory function in which the workers participate as it is a workers' function in which the supervisor participates. Workers must be involved in training. They must have some understanding of the "why" things are done. They must be interested in learning how to do the job in the best way or else training is not productive.

We now come to the central func-

*Viguers, Richard T.: Who's on Top: Who Knows? Mod. Hosp. 86:51 (June) 1956.

tion of supervision, which is directing or motivating. This involves getting the work done and unless this function is carried out all other functions of supervision are unproductive.

Basically we are motivated by a series of rewards and punishments. This is true whether we are training an animal, a child, or an adult. We guide our behavior by the rewards we receive for doing what is wanted or expected of us, and the punishments we receive for doing the wrong or undesired things. These rewards are in the form of salary, promotion, prestige, statements of appreciation, and commendation, and the punishments are in the form of withholding pay increases, withholding promotions, criticism for the action, or blame for failing.

We all move toward the goals we have set for ourselves. Each one of us has certain specific goals but in general we have certain common goals. We speak of these in terms of security, self-respect and a chance to participate. The worker wants security not merely in the sense of not losing his job but in the sense of having resources on which he can draw to give him a firm foundation. He wants to be respected as a person and he wants a chance to participate in the development of policies and a chance to know what is going on.

The worker tends to move toward his own goal and not necessarily the goals of the supervisor, and it is there-

THE RULE FOR DEVELOPING SKILL AS A SUPERVISOR: KNOW YOURSELF

IF THE supervisor is to develop his skills of supervision he must begin by looking at himself and examining how he is doing. It is all too easy to put the blame on someone else, to say that the workers are stupid or not interested in their job, or that they do not work the way they used to in the "good old days." Too often, educational meetings are devoted to discussions of how to educate someone else. Supervisors meet and talk about how they need to educate department heads. Department heads want to educate the administrator. The administrator wants to educate trustees. Trustees put the blame on the administrator and want to educate him. The administrator says things would be fine if he only had good department heads. Department heads in turn want better supervisors, and supervisors want better workers. This is all very true, but it is not very helpful. Each group should start by improving itself.

The first step in good supervision is to study ourselves and say "What about me; how am I doing my job as supervisor?" and to consider our appearance, attitude and method and not to talk continuously about "the stupid employe."

Suppose a porter is mopping the corridor floor and fails to put up warning barriers and another employe comes along the corridor, slips on the wet surface, falls and is injured. Our first reaction as a supervisor is to say, "That stupid porter! How many times have I told him to put up warning barricades when he is mopping the floor?" This is quite natural but we should follow it up with a question about "What did I, as supervisor, do wrong? Did I really explain to him what should be done? Did I make it clear to him the reasons for putting up the barricade? Did I give him the necessary tools and time to put them up and mop the floor as it should be done, or did I give him so much floor to cover that he could not do it? How can I prevent this from happening again?"

This does not imply that the supervisor should feel inferior or should get upset with every failure of an employe. The supervisor should start with the feeling that he is a good supervisor and the fact that he has been made a supervisor is evidence of his ability. The supervisor asks himself what he did wrong only so that he can become a better supervisor and do a better job.

A supervisor in the typing pool finds that Miss Jones has made only one copy of a report when two carbons are necessary; therefore, the whole report must be done over again. The supervisor walks out to the area where the typists are located and says in a sharp voice "Miss Jones, come into my office." Miss Jones comes into the office and promptly breaks into tears. The supervisor wonders, "What did I do wrong? I know you should not correct employes in front of others. All I did was ask her to come into the office so that I could tell her she did not make the necessary number of carbons."

What the supervisor failed to recognize was that his very tone of voice and approach was such that everyone in the office knew that Miss Jones had done something wrong and was going to get bawled out when she went into the office. The supervisor was following the letter of supervisory instruction but he was totally failing in the spirit. He had no understanding of the employe's feelings and no empathy for the employe. Skill in supervision necessitates understanding what is going on in the minds of others.

The fundamental rule of acquiring this understanding is to set a climate that is cordial and permissive and then to listen to what the employe has to say. Listening is not easy, but, if you want to find out, you have to listen and then listen some more.

Also, if we are to develop skills of supervision we have to have some knowledge of our own blind spots. We have to know what we object to in others so that we can be on guard and try to control our emotional responses. If we object to people who are overbearing or aggressive, for example, then, keeping this in mind, we can deal more fairly and wisely with people who are overbearing.

This matter of developing the skills of supervision involves much looking inward. To be a good supervisor we need to understand the workers and to understand the workers we need to have some knowledge of ourselves, of our strengths, of our weaknesses. We need to have the courage and wisdom to admit our own part in the failure and then do something about it.

This does not mean psychiatric analysis and it is not dangerous because the mind has natural stops if we tend to go too far. We all accept only the things we are ready to accept. What it means is just a common sense approach. We start with the knowledge that we are good supervisors or we would not be holding our jobs and we move on to be better supervisors by adopting an attitude of understanding of others and an understanding of ourselves. It is not easy but it is very rewarding.

fore the responsibility of the supervisor to understand the worker's goals and to help the worker see how these can be achieved by working for the goal of the supervisor.

Another function of the supervisor is to coordinate. He not only needs to coordinate the workers under his supervision but he also has a responsibility of coordinating his department or group with the work of other groups. Both workers and management expect the supervisor to be a coordinator, to be able to stand off a bit from the work and smooth out the work flow, to see that the other departments do their part of the job, and that the combined activities of the departments move along toward the total goal of the hospital.

Coordinating with other departments means that the supervisor must learn to work with others. He must understand something of the job that the other departments have to do and be on good terms with the other supervisors. It is not enough for the supervisor merely to stand up for his department or section. He must fit into the total operation and be able to work with other department heads and other supervisors just as he expects his workers to work together.

Evaluation is a frequently neglected function of the supervisor. Evaluation includes evaluation of himself, evaluation of his department, and evaluation of the individual workers. The supervisor should sit back periodically and try to determine how well his department or group is doing. This measurement can be done in terms of the objectives which were set. Have the objectives been achieved? If not, why not?

A periodic review of the work of each employe is a necessity. Of course, this is done on an informal basis from time to time but at least several times a year the supervisor should sit down privately with each worker and go over his achievements and his failures, his strong points and his weak points, what has been expected and what has been accomplished.

This is not an easy thing to do and we all try to avoid it, but a supervisor owes this to his workers and to himself. Too frequently, when a worker must be discharged, it is learned that his failures have never been discussed with him. Periodic evaluation is not only the fair way to deal with an employe, but it also helps the supervisor to get the maximum production from the employe.

The last in this list of functions of a supervisor is to report. Reporting to management should be looked upon by the supervisor as an opportunity to tell management what a good job he has been doing. These reports, whether they are formal or informal, written or oral, are the principal opportunity the supervisor has to get across what he has accomplished. I suppose it is true that if you build a better mousetrap the world will beat a path to your door but it does not do any harm to send out a few reports telling how good the mousetrap is.

Management will usually require certain reports of the supervisor. In addition, the supervisor may develop his own statistics and reports, which act as an evaluation of the work being done, as a record of what has been accomplished, and as a method of communication up the line. #

Successful Supervisor Must Be Natural Leader, Lecturer Tells Nurse Institute

Los Angeles.—The graduate nurse in the hospital today must function as a medical technician, leader, supervisor and individual, Lewis M. Letson, administrative assistant at St. Francis Hospital, Lynwood, Calif., said in a paper presented at an Institute for Registered Nurses last month.

Emphasizing the nurse's supervisory rôle, Mr. Letson said successful supervisors combine the authority of their positions with natural leadership. Explaining the difference between supervision and leadership, he added:

"Supervision suggests and is indicative of a form or degree of authority vested in the position you hold. Leadership does not necessarily contain any element of authority but is the exemplification of those natural qualities which inspire your fellow nurses to follow your example in thought and action."

WORK THROUGH OTHERS

For the nurse, successful supervision requires that she bring to bear on the patient's needs, through the acts of other human beings, the services that will return the patient to health, Mr. Letson explained.

"The rôle of the supervisor, therefore, requires a knowledge of how to perform these services and yet does not necessarily involve the personal application of this knowledge," he said.

Another necessary quality of good supervision is flexibility, it was explained.

"Flexibility suggests application of judgment to a given set of circumstances," the speaker said. "Being a supervisor is almost like being a parent. How often do we find ourselves responding in the negative to an inquiry or a request for permission, when a moment's reflection makes us realize there was no need for denial of the privilege or request?

"The easiest course and the one requiring the least judgment on the part of a supervisor is that in which inflexible rules are applied to situations indiscriminately."

To find satisfaction in her supervisory function, the nurse must frequently resolve an internal conflict between a concept of supervision she may have developed in a climate of autocratic and hierarchical control, on the one hand, and the desire to be accepted by her fellow workers as a member of the same team on the other, it was suggested.

For example, the nurse supervisor may prefer to live with her fellow workers in a relationship similar to that which she enjoyed with her fellow students when she was in nursing school, Mr. Letson explained.

"This is impossible," he stated. "Look for a moment at the supervisor as viewed by the person over whom supervision is exercised. You represent to that person two figures: (1) the benefactor and (2) the disciplinarian.

"You have to some degree the ability to determine the type of work the person shall do, or the privileges which she may enjoy. Your concept of discipline can affect her income, her chances for promotion, or perhaps even her job. This relationship did not exist between you and your fellow student nurses."

Frequently, the supervisor's interests and concerns as an individual are in direct conflict with her responsibilities as a supervisor, Mr. Letson concluded.

"As a nurse, you must subjugate to some extent your individual nature to the over-all requirements of your employment environment," he pointed out. "There is no place in modern society where the effects of environment are not reflected in your personal life and conditions of work. If your requirements are in conflict with your professional work, you will either resolve this conflict or institute some method of adaptation to compensate for it.

"In order to be a truly happy and productive working individual, you must recognize these areas of conflict, reduce them to a minimum, and align your personal goals with the realistic demands made upon you." #

Staff Participation Is a Matter of Record

Under this system of recording the physicians' performance, medical staff assignments can be made on the basis of evidence, not guesswork

Henry Gothelf and Audrey Seskind

THE governing body of the hospital has a legal and moral obligation to appoint ethical and competent physicians to its staff. In essence, the quantitative performance review developed at Sinai Hospital, Detroit, is a method of assisting the board and the medical staff during that period when yearly appointment time approaches.

The system of making appointments on *estimates* of reputation or competence too often prevails. Competence and ethics should not be the sole factors for reappointing a physician to the medical staff. His whole relationship to the hospital should be considered, *i.e.* his interest and participation in hospital activities, devotion and dependability in carrying out his assignments, use of the hospital's facilities, contributions to the hospital's advancement, and maintenance of its high standards.

When the board of directors of a business enterprise wishes to evaluate its performance for a given period, it relies to a great measure on its accounting system. Books of original entry, ledgers and financial statements provide the necessary information for the directors to determine whether the constituted personnel organization is performing in a way that brings credit and profit to the company.

Similarly, it should be possible to evaluate the performance of each member of the medical staff of a given hospital, so that the governing body may determine along with the medical advisory committee whether a physician is making a worth-while contribution to the hospital. So, the quantitative performance review concept was born at Sinai Hospital and we will attempt to describe it here.

For each physician, some 500 in all, there is kept an individual performance review "ledger sheet," in a loose-leaf notebook, referred to as the "Physicians' Ledger." It is the responsibility of a secretary in the administrative office, who is, in effect, the medical staff "bookkeeper," to maintain the records of original entry, ledgers and statements necessary to the performance review system. (Any resemblance to books of account is purely coincidental.)

The "ledger sheet," as illustrated in Figure 1, encompasses all the information that the governing board and medical staff require to evaluate the performance of an individual physician, as a requisite to his being a member of the medical staff of the hospital. The following is an explanation of the columnar headings in detail, and the sources of the information recorded:

The identification data include the physician's name, original date of appointment to the hospital staff, original rank, date of birth, eventual retirement date, division and section and subsection to which he is appointed, A space is provided for any subsequent change in rank or status, thereby giving a complete picture of his position on the medical staff from the original date of his appointment to the present time.

This information is obtained originally from the physician's application for appointment to the medical staff, and the minutes of the board meeting approving his appointment. The date of birth and retirement date are important, as there is a mandatory retirement age of 65 and the physician must be assigned to an "off service" status when he reaches this age. The "ledger sheet" is most helpful in implementing this and other rules and regulations.

Performance Data

The performance data include the "bed usage"; "attendance" (at required meetings and miscellaneous extracurricular meetings[1]); "outpatient de-

Henry Gothelf is assistant director at Sinai Hospital, Detroit, where he served his administrative residency. He also directs North End Clinic, the outpatient department of the hospital. Mr. Gothelf received a bachelor's degree in accounting from City College of New York and his master's degree in hospital administration from Columbia University. He is a nominee of the American College of Hospital Administrators. Audrey Seskind is administrative secretary at Sinai Hospital. She held secretarial positions in industry and law before entering the hospital field. When Sinai Hospital opened in 1953, Miss Seskind was assigned the duty of recording and compiling data concerning medical staff activities. From this, in collaboration with Mr. Gothelf, she developed the comprehensive review of staff performance.

FIG. 1. THIS FORM KEEPS TAB ON PHYSICIAN'S WORK

Name: WHITE, JOSEPH Original Appointment: 6/30/56

Birthdate: 1/21/27 Retirement Date: Jan. 1993 Original Rank: Voluntary Assistant

DIVISION: Medicine SECTION: Internal Medicine SUBSECTION: General Medicine

Month 1956	Bed Use	ATTENDANCE				SERVICE		D/A	Miscellaneous; Committees; Etc.	Rank
		Div. Conf.	Gen. Stf.	C P C	Misc.	OPD	Hospital Teach. Cons.			Date Status
July	4	√		√		√ 4/5			Civil Defense #8	1/22/57 Vol. Asst.
Aug.	3	√			A G	√ 4/4			Record #24	
Sept.	3	√		√	G A	√ 1/4				
Oct.	4	√		√	A	√ 4/5				1/22/58 Junior Physician
Nov.	4	√		√	G	√ 2/4				
Dec.	11	√	√	√	A	√ 2/3		1/1		
1957 Jan.	4	√			A E	√ 4/4				
Feb.	5	√		√	A E		T			
Mar.	4		√	√	A G					
April	2	√		√						
May	1	√		E	A G					
June	0	√		√	A E					
TOTAL	45	10/12	2/4	10/12		21/29		1/1		
July	6				A	√			Cancer Reg. & Tumor Board #6	
Aug.	5	√			A	√				
Sept.	5	√		√		√			Library #17	
Oct.	6	√		√	A E	√				
Nov.	5	√		√	A E G					
Dec.	7	√		√	A E					

KEY TO SYMBOLS ON PHYSICIANS' ACTIVITIES SHEET

D/A = Number of Deaths/Number of Autopsies obtained

The following are shown as *"other" attendance* and are extracurricular activities:

A = Attendance at G.I. Meeting(s)
B = Attendance at Radiology Meeting(s)
C = Attendance at Metabolism & Endocrinology Meeting(s)
D = Attendance at Allergy Meeting(s)
E = Attendance at Cardiac Meeting(s)
F = Attendance at Pulmonary Meeting(s)
G = Attendance at Tumor Board Meeting(s)
H = Attendance at Dermatology Meeting(s)
I = Attendance at G.U. Meeting(s)

Note: See Also Key to Committee Membership on Page 70

partment (indigent clinic) service"; "teaching and consultant assignments"; "D/A" (number of deaths as compared with the number of autopsies performed); "committee membership," and "misc." (scientific accomplishments, *i.e.* papers, research). It is the total performance in which we are interested.

Bed Use

These data are most readily available on the "Physicians' Index," maintained in the record room. The record of original entry is a bed usage report submitted to the bookkeeper by the record room each month and the data are posted to the ledger sheet as indicated.

No small part of a physician's performance can be attributed to the number of patients he admits, *i.e.* as Sinai is a teaching hospital with a large house staff, and relatively few attending staff beds, those physicians with few patients admitted, in most instances, have little opportunity to contribute to the education of the house staff.

Attendance

Attendance at required division and general staff meetings and clinicopathological conferences, and at elective conferences and meetings, is greatly encouraged. Each month a pocket size card is printed and sent to each physician on the staff, listing all conferences and meetings scheduled for that month (Fig. 2). From this card the staff members can determine which meetings are required and which meetings they can participate in as extracurricular activities.

The attendance sheets list all members of the medical staff, according to divisions, and are preprinted with a space opposite the physician's name for his signature. At the top of the attendance sheet there is a space for insertion of the date, time, place and name of the meeting. Every meeting on the conference card requires an attendance sheet. The sheet is prepared in advance and placed in the appropriate conference room on the day of the scheduled meeting so that the physicians may sign in. After the meeting the attendance sheet is brought to the director's office by the chairman of the meeting, where the bookkeeper records the attendance (√) on the ledger sheet in the proper column and files the attendance sheet in a master file for future reference.

This system should prove valuable

[2]The miscellaneous extracurricular meetings are included under "attendance" but are not required meetings. In order to utilize the small space provided for recording attendance at these meetings, which attendance enhances the physician's record, we have found it necessary to use a code instead of the actual name of the meeting or conference (See Figs. 1 and 3).

to the examiners of the Joint Commission, in that they can see whether attendance at required meetings is being met. The record of original entry is filed and can be referred to if the authenticity of the entry is questioned. The signature of the doctor can be compared to his signature on the by-laws or on his application for appointment to the medical staff.

Excused Absence From Meetings

If a physician cannot attend a required conference, a request for excused absence from the meeting is submitted in writing or by telephone to the director's office. A preprinted form is filled in and forwarded to the secretary of the staff for consideration. If approval is given it is indicated by the appropriate check mark and signature and an "E" is written in the space provided on the ledger sheet for that particular meeting, and the signed, approved excused absence form is filed in the doctor's personal folder. An official "excused absence" is considered favorably when computing the doctor's attendance and the percentage of the entire staff's attendance for Joint Commission approval purposes.

If too many excused absences appear on the physician's record, an interview is conducted by the secretary of the staff to determine the reason. If the request for excused absence is not approved, the doctor is considered absent.

Service

1. *Outpatient department:* Service in the outpatient department (indigent clinics) is a requirement for most physicians on the active medical and dental staffs. Assignments are made annually by section and division chiefs. Each division and section has a different period of service, varying with the number of clinics held per month and the number of available physicians. The record of original entry for the monthly assignments is the division assignment sheets. An entry is made (code letter "D") in the proper box at the beginning of the fiscal year to establish the fact that the doctor is expected to serve in the OPD.

Individual attendance records are maintained in the OPD. At the end of the fiscal year these records are sent to the bookkeeper for posting. These attendance records represent a count of the number of required sessions the physician was *expected* to attend and the number he *actually* attended, with absences fully explained. The physician's individual record is totaled and the information is entered onto the ledger sheet (*e.g.:* 14/18=14 clinics attended/18 clinics scheduled). This phase of a doctor's performance is most important in evaluating the contribution he is making to the hospital and community. The attendance record is filed in the physician's personal file.

2. *Consultant and teaching assignments:* The hospital maintains a staff service (indigent and/or clinic service) and physicians are assigned to do teaching and consulting work on these inpatients to foster the house staff training program. Activity in this area is also important in evaluating the physician's contribution to the hospital.

Assignments are made in much the same way as OPD assignments are, and credit is given where the doctor's name appears on the division assignment sheet. No attendance records are kept as it was found to be impractical. Besides, the over-all hospital consultations percentage is indicative of the performance of these men to some small degree. The letter "C" or "T" is recorded in the appropriate column and month and designates the doctor's assignment and thus his contribution. He is on call for the entire month assigned.

Fig. 2. The schedule of conferences and meetings is printed on wallet sized cards for the convenience of those who must refer to them. One card covers meetings and conferences scheduled for one month only. Each physician on the staff gets a similar card.

SINAI HOSPITAL — MAY 1957
SCHEDULE OF CONFERENCES & MEETINGS

DATE	TITLE	HOUR	ROOM	IN CHARGE
Su. 12	*Orthopedic	11:00 a. m.	Board Room	P. Shifrin
Mo. 13	*Ob./Gyn.	8:00 a. m.	Main Lect.	E. Rothman
We. 15	Metab./Endo. Seminar	11:00 a. m.	1st Fl. Lect.	S. Klein
Th. 16	*C. P. C.	8:00 a. m.	Main Lect.	S. Kobernick
Th. 16	Cardiac	9:00 a. m.	Main Lect.	S. Rosenzweig
Sa. 18	Tumor Board	8:30 a. m.	Main Lect.	H. Chapnick
Th. 23	Allergy	8:00 a. m.	Main Lect.	M. Fenton
Th. 23	*Med. Div.	9:00 a. m.	Main Lect.	R. Sokolov
Mo. 27	*Dental	8:30 p. m.	Main Lect.	H. Bloom
Tu. 28	*Psychiatry	8:30 p. m.	Main Lect.	H. August
We. 29	Cleft Palate	9:00 a. m.	Dental Rm.	H. Bloom

* — REQUIRED ATTENDANCE

D/A (number of deaths/number of autopsies performed): A list is submitted from the laboratory to the bookkeeper each month showing the number of deaths and the number of autopsies performed and the physician responsible for the case. This is recorded as follows: 3/2, which means that out of three deaths two autopsies were obtained in a particular month. These data further indicate the physician's net worth to the institution. Autopsy refusal reports are required in those cases where postmortems are not obtained, and it is the responsibility of the physician to complete and submit this report.

Miscellaneous, Committees and so on

This is the over-all column. For committee work the record of original entry is the list of standing committees appointed annually by the medical advisory committee. There are some 30 to 35 standing and special committees in order to carry out the policies of the medical staff and board of trustees. Those committees of which the physician is a member are recorded on his ledger sheet in this column.

Physicians are asked to submit to the bookkeeper all information about their activities that would indicate their desire to advance professionally, such as research projects undertaken, papers published, lectures given, teaching appointments held, national or local meetings attended, society memberships, board certifications, and so on.

All these data combine to give a good indication of the caliber and performance of the man. This information is recorded on the ledger sheet, and the original memorandum of notification is then filed in the physician's personal file.

Statement

When the fiscal year comes to an end, the attendance and other data are totaled and we are ready to prepare our "Statement,"[2] which is the end product we have been striving for. Consideration as to reappointment and/or changes in rank or status must begin some two to three months before the end of the calendar year, so that all is in readiness when the December board of trustees meeting is held to consider staff reappointments.

The bookkeeper requires ample time to complete the data and present them in the proper way; therefore, the fiscal year of July through June

[2]Not only are the names of the extracurricular meetings coded but so are the committee names. This is done to facilitate recording of data in the limited space provided. A code key sheet is supplied with the "Statement" so that the symbols used may be easily deciphered. (See Figs. 1 and 3.)

is used for performance review purposes, although actual appointments are reviewed annually and are made for the calendar year. This method has proved satisfactory for the bookkeeper, as well as necessary, because she must integrate this bookkeeping into her regular secretarial duties. Allowing sufficient time for compiling the "Statement" in a comprehensive manner has permitted her to assume the extra duty without inconvenience.

Each section chief receives a "Statement" (Fig. 3) of the performance of each physician in his section with only the "Recommendation" column left blank. The section chief indicates his recommendations in this column and then submits the "Statement" to the division chief who, in turn, reviews these recommendations. The division chief may question or change such recommendations after consultation with the section chief.

The division chief next presents the "Statement," together with his recommendations for the members of his division, to the medical advisory committee for approval. The division chiefs are members of this committee. Any member of this group may examine the performance record of any physician and may question the recommendations of the other division chiefs.

After the medical advisory committee has reviewed a division chief's recommendations and either approved, disapproved or changed them, the "Statement" moves on to the joint conference committee (lay members of the board and medical members of the medical advisory committee) where it is again reviewed and, if necessary, challenged. The joint conference committee's recommendations on the "Statement" are then submitted to the board of trustees.

It is here that the performance data receive their final review, and here that staff reappointments are decided. Pointed questions may be asked, and the board may approve or disapprove the recommendations of the joint conference committee.

For example, a physician who uses five beds a year, attends occasional meetings, does not attend clinic or participate in teaching activities at the hospital, and whose ethics and competency are beyond question, is recommended for promotion to attending physician by the joint conference committee. The board asks: "Is this man contributing to the hospital?" His performance record shows that he gives little and, therefore, his promotion is likely to be disapproved until such time as he participates to a greater degree in hospital activities.

At any time during the period before final board approval is given to the reappointments recommended there is every opportunity to question and discuss the recommendations. The board of trustees, the medical staff, and the community can look with greater confidence to the constituted medical staff as representing the best the hospital can offer. Further, the medical staff members can feel that they have been noticed and rewarded for contributing to the advancement of the hospital.

CONCLUSIONS

The advantages of the "Physicians' Ledger" method of medical staff accounting can be summarized as follows:

1. Personalizes each physician's per-

(*Continued on Page 120*)

FIG. 3—INDIVIDUAL PHYSICIANS' ACTIVITIES—JULY 1956 THROUGH JUNE 1957

DIVISION: MEDICINE **SECTION:** INTERNAL MEDICINE **SUBSECTION:** GENERAL MEDICINE

Name	Bed Usage	D/A	ATTENDANCE AT MEETINGS					N. E. C.		HOSP. SERVICE		Committee Membership	ORIG. APPT.		Present Rank	Comments	Recommendation
			Div. (12)	Sec. (0)	C.P.C. (12)	Staff (4)	Other	#Mos. Assign.	Sessions Att/Req.	#Mos. Assigned			Date	Rank			
										Teaching	Consult.						
Brown, Joseph....	41	0/0	6		4	3		4	13/26		2		'52	Jr.Phys.	Assoc. Attend.		No Change
Green, William...	22	6/2	7		5	3						#12	'52	Assoc. Attend.	Assoc. Attend.		No Change
Jones, Charles....	52	1/0	4		5	4	A, B, E	4	10/17	1		#11, #17	'52	Jr. Phys.	Jr. Phys.		No Change
Smith, John.....	159	6/4	11		12	4	B, E, F, G	4	15/17	1		#15, #21	'54	Jr. Phys.	Jr. Phys.		Assoc. Attend
White, Joseph....	45	1/1	10		10	2	A, E, G	7	21/29	1		#6, #21	'56	Vol. Ass't.	Vol. Ass't.		Jr. Physician

KEY TO "COMMITTEE MEMBERSHIP"

1 = Abortion & Sterilization Committee
2 = Absract Bulletin Committee
3 = Admissions Committee
4 = Advisory Committee to Shapero School of Nursing
5 = By-Laws Committee
6 = Cancer Registry & Tumor Board
7 = Central Supply Committee
8 = Civil Defense Committee
9 = Editorial Committee
10 = Education Committee
11 = Formulary & Drug Committee
12 = Home for Aged Coordination Committee
13 = House Staff Administration Committee
14 = House Staff Selection Committee
15 = Isotope Committee
16 = Laboratory & Postmortem Committee
17 = Library Committee
18 = Mortality (Med.) Committee
19 = Mortality (Surg.) Committee
20 = Nursing Committee
21 = Nutrition Committee
22 = OPD Committee
23 = Program Committee
24 = Record Committee
25 = Research Committee
26 = Surgical Committee
27 = Staff Audit Committee
28 = Staff Fund Committee
29 = Tissue Committee
30 = Staff Executive Committee
31 = Medical Conference Committee

Note: See Also Key to Symbols on Page 68

N.E.C. = North End Clinic

The Modern Hospital of the month

These hospitals are identical twins

Two heads on one body make a monster but two hospitals with one head make a workable institution rendering care to the communities of Wayne and Lincoln Park, Mich. On the drawing boards is the third section of this unusual structure.

The two hospitals now in operation in Wayne and Lincoln Park have been named, respectively, Annapolis and Outer Drive. The "head" that governs them is the Peoples Community Hospital Authority, which was created by state law in 1945 and is composed of representatives of 17 cities, villages and townships in western Wayne County and eastern Washtenaw County.

The structures are identical in size, design (except for the foundation work) and organization. Each has 122 beds expansible to 250. (See architect's description, plans and photographs on the following pages.)

The chain of command works down from the over-all Hospital Authority through its board of directors to an operating committee for each hospital, which serves, in effect, as the board of trustees and is responsible for the operation of the institution and for selecting the superintendent. The superintendent of each hospital has general charge of administration and hires and fires technical and professional personnel, subject to confirmation by the operating committee.

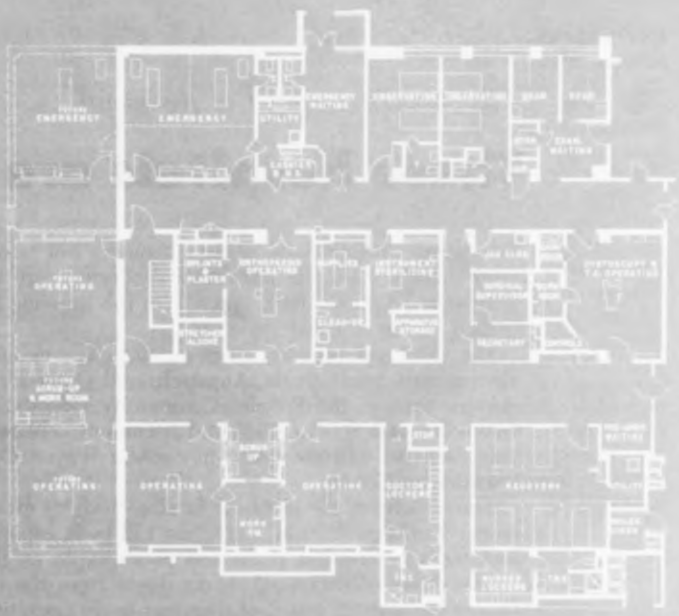
Professional arm of the Hospital Authority is the medical advisory committee appointed by the board. With the approval of the board of directors the medical advisers adopt rules, regulations and policies to govern the professional work of all hospitals in the authority and the eligibility and qualifications of their medical staffs. On the individual hospital level, the chief of staff serves as ex officio member of the operating committee. Amendments to the by-laws and rules and regulations governing the medical staffs must be submitted to the medical advisory committee before they are presented to the board of directors.

Administrative duties of the Hospital Authority devolve upon a three-man executive committee, with an executive director serving as general business officer for the board.

Kenneth W. Gremore is executive director of the Peoples Community Hospital Authority. Superintendents of Annapolis and Outer Drive hospitals are, respectively, Arthur C. Forche and Walter S. Wheeler.

Exterior of one of the twin hospitals (Annapolis) built by the Hospital Authority.

Right: An enlarged version of the combined emergency and surgical suite at Annapolis Hospital, Wayne, Mich., shown in cut-out section of large plan. Contiguity of the emergency department to the operating room section results in elimination of duplications.



COMBINED EMERGENCY & SURGICAL SUITE

FIRST FLOOR PLAN

Left: Plan of first floor. All central services, kitchen, laundry and ancillary facilities are oversized to accommodate final bed capacity.

GROUPING OF DEPARTMENTS ACCORDING TO FUNCTION EXPANDS EFFICIENCY

Adolf H. Roessling and Christopher Parnall, M.D.

IN DEVELOPING a building program for the two hospitals operated by the Hospital Authority certain basic requirements were postulated:

1. *Expansion.* Since both the areas served by the hospitals are within a rapidly growing industrial section, early expansion had to be planned. This planning took the form of vertical duplication of patients' bed floors with oversized service areas on the first floor capable of further enlargement by horizontal expansion. Each hospital of 122 beds can, with relatively little change in service facilities other than the addition of equipment, be enlarged to 250 beds. The initial "per bed cost" will be somewhat higher but future expansion of capacity can be effected at relatively low cost.

2. *Nursing units.* These are so related and of such size as to be most economically and efficiently operated.

3. *Relation of ancillary services.* X-ray, laboratory, emergency, operating room, and pharmacy are related to each other and to the hospital generally.

4. *Storage and distribution of supplies.* This is not a haphazard jumble but a carefully worked out arrangement, recognizing a major function.

5. *Separation of public areas from service functions.*

6. *Multiple use.*

Reference to the drawings shows an expanded first or ground floor providing space for all services other than the delivery suite and the accessory facilities in connection with the patients' rooms. Because of the nature of the sites in the case of both hospitals only a limited basement area was planned. The typical patient floor is in the form of a cross; each of three wings constitutes a nursing unit, and the fourth contains the main service units for the floor. This fourth wing has two corridors, separating service traffic and public movement. Near the elevators is a commodious dayroom for patients and visitors which may also be used for dining service for ambulatory cases.

A main nurses' station is centrally located to control the floor completely. Communicating with the nurses' station there is a separate chart room for doctors.

On each floor there is a distribution room near the service elevators, and served by dumb-waiters which run to a central distribution area on the main floor. This room is intended, during busy hours, to be manned by an attendant whose duty is to expedite supplies and equipment to the nursing units, thus avoiding the necessity for nurses to leave their posts and interrupt their professional care of patients.

Except for one "de luxe" room located on each nursing unit all rooms are uniform in size, adaptable for either one or two beds as may be required, and each has toilet and lavatory. The rooms are planned on a unit basis, 12 feet on partition centers. Modification of the typical arrangement is required in the maternity and pediatric areas in order to adapt the space for the special requirements of these departments.

On the first floor the lobby opens on a public corridor from which all service activities are excluded. One side leads to the dining rooms and conference room, the other to the business offices and outpatient waiting space for x-ray and laboratory service. A service corridor in the rear provides a separate transportation route between service elevators, operating rooms, emergency, x-ray, laboratories, central supply, pharmacy, kitchen, locker rooms, laundry, necropsy room, stores and service entrance. The number of entrances has been held to a minimum.

Worthy of particular note is the location of the emergency department, the operating rooms, the x-ray department, and the laboratories in reference to one another and to their access for the treatment of both inpatients and outpatients.

Another functional grouping of interest embraces the general stores, central supply, pharmacy and supply distribution. Generally, all supplies except food are routed through a central distribution center which, in effect, is the "wholesale store." Not because the central supply and sterilizing function necessarily should be an adjunct of the operating suite but rather because it could conveniently be located near the surgical department, a direct access has been provided between them.

The contiguity of the operating room section to the emergency department permits an arrangement whereby expensive space is saved by a "multiple use" principle. A single adequate fracture room, for instance, serves both sections. Duplication of costly instrument sterilizers is avoided

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made by the committee each month.

OUTLINE OF CONSTRUCTION COSTS

Total construction cost		**$2,704,735.37**
No. of beds	**122 (planned for 128 additional)**	
Cost per bed		**21,130.74**
Total square feet	**102,690**	
Square feet per bed	**802**	
Cost per square foot		**26.34**
Total cubic feet	**1,289,835**	
Cubic feet per bed	**11,076**	
Cost per cubic foot		**2.10**

This article was prepared with the collaboration of Kenneth W. Gremore, executive director of the Peoples Community Hospital Authority, Wayne, Mich.

Mr. Roessling is project director for hospitals, Smith, Hinchman and Grylls, architects and engineers, Detroit, and Dr. Parnall is a hospital consultant, Ann Arbor, Mich.

by having one instrument cleanup room and one instrument sterilizing room for both surgery and emergency. Argument as to whether the cystoscopic room properly belongs to x-ray or to surgery is avoided by having the cystoscopic room almost equally accessible to both.

Another example of multiple, or perhaps more properly of expansible, use is the arrangement and location of the conference room, which normally seats 30 persons but which by opening a folding partition separating it from the private dining room can be increased in capacity to seat twice that number.

A considerable area is of one-story construction. This is partly because of the restricted basement but more on account of the fact that dimensions suitable for patient bed care seldom allow for the most advantageous arrangement of service functions. In order to effect the best grouping of such services they must be planned outside the main envelope of the structure dictated by the shape and size of the patient bed area.

Whether the criteria initially set up have been realized remains to be demonstrated in the operation of each hospital. However, it would appear from careful study that convenience of arrangement of the various units, their relation to each other, and ease of control of circulation should assure efficient operation with a minimum number of personnel.

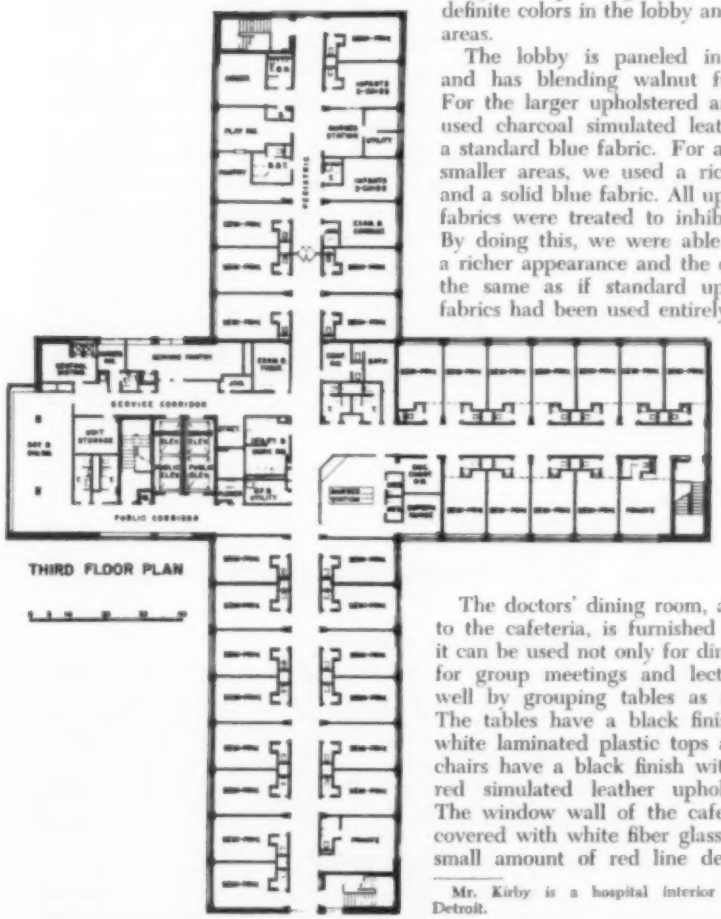
SECOND FLOOR PLAN

Top: The lobby of one of the twin hospitals (see also color photograph on cover). Paneling is walnut and the furniture blends with it. For large upholstered areas, charcoal simulated leather and blue fabric were used. All fabrics were treated to inhibit wear. Center: Snack bar is decorated in pumpkin color with a soft lemon and beige. Bottom: Each patient floor has a day-dining area for patient dining, with a lounge area at one end. Colors used are turquoise for one and pumpkin for the other. Right: Plan of second floor shows central location of nurses' station to control the traffic.

COORDINATION IS THE KEY TO PLANNING THE INTERIOR DECORATION

William G. Kirby

Below: Plan of the third floor. Three wings constitute the nursing divisions.



THE colors used throughout the building are coordinated, soft pastel tints in the patients' rooms and corridors; pink, blue and white in the nursery and pediatric areas; green tile and soft grays in the laboratory, examining and operating areas, and more definite colors in the lobby and dining areas.

The lobby is paneled in walnut and has blending walnut furniture. For the larger upholstered areas, we used charcoal simulated leather and a standard blue fabric. For accent in smaller areas, we used a rich stripe and a solid blue fabric. All upholstery fabrics were treated to inhibit wear. By doing this, we were able to give a richer appearance and the cost was the same as if standard upholstery fabrics had been used entirely.

The doctors' dining room, adjacent to the cafeteria, is furnished so that it can be used not only for dining but for group meetings and lectures as well by grouping tables as needed. The tables have a black finish with white laminated plastic tops and the chairs have a black finish with deep red simulated leather upholstering. The window wall of the cafeteria is covered with white fiber glass with a small amount of red line design to unite the entire area when the dividing screens are open.

Each patient floor has a day-dining area furnished for patient dining with a lounge area at one end, which encourages patients to leave their rooms when it is not necessary to be confined to their beds. These rooms have cheerful colors for the same reason: a pumpkin color for one and turquoise for the other. The same pumpkin color is used in the first floor snack bar along with a soft lemon and beige.

All surface tops in the patients' rooms and public areas are laminated plastic. The lounge chairs in the patients' rooms all have wall-saver legs. Because of the need for additional seating, each patient room was given one or two matching ottomans since they require little space and can be put under the beds if not needed.

We had a problem of window coverings for the patients' rooms. We needed something that would block light almost completely when necessary and we did not want to use shades or blinds or, because of maintenance, a lined curtain. We selected a special fabric with an aluminized backing which solved all problems of maintenance, as well as light and heat control and appearance at a very nominal cost. Most of the windows have wooden sash and are reversible to facilitate cleaning from the inside.

In areas such as the nursery, laboratories, kitchens, laundry and other work areas where more than an average lint and maintenance problem existed, wooden roll shades were used in off-white and soft gray which resulted in low maintenance, good appearance, and good control of light and temperature.

Mr. Kirby is a hospital interior designer, Detroit.

Below: Typical patient room, adaptable for either one or two beds. Each room includes a toilet and lavatory.

Below: Main nurses' station is centrally located so that the nurse in charge has complete visual control of the floor.

What Hospital and House Staff Owe Each Other

OF LATE we have heard much discussion about whether the administrator should attend professional staff meetings. Whatever views one may hold on this subject, one thing is certain: If the administrator *did* attend staff meetings, he might learn more about what the staff expects of the hospital. He might also have a chance to tell the staff what the hospital expects of its doctors. It is shortsighted to think that the professional staff and the administrative staff represent two separate areas, each going its own way. What happens to one affects the other in the united effort to bring better care to the patient. Especially is this so regarding the members of the house staff.

On these two pages are listed some of the points at issue between house officers and the hospital administration: in the left-hand columns, the things interns and residents feel they have a right to expect from the hospital, and in the right-hand columns, what the hospital expects from house officers.

A review of this summary should convince both sides that the administrative staff, as represented by the administrator, and the professional staff, represented by the house physician, must work together for the best care of the patient and to fulfill the hospital's obligation to its community.

Leon Ross, M.D.

WHAT HOUSE STAFF EXPECTS OF HOSPITAL

Respect as a Doctor

Above all things, the house officer wants to be treated like a doctor. One of the frequent complaints of house officers is that the administrative staff, especially the administrator, often treats them as just cheap labor. However, this is sometimes a personality factor in the life of the individual and often when a house officer is not treated like a doctor it's because he doesn't act like one.

Clinical Material

One of the primary factors that governs a house officer's selection of a hospital is the availability of clinical material for his specialty. A young doctor likes to know that the cases he will see in the hospital represent a cross section of the work found in his specialty and that there will be a sufficient quantity so that these cases appear often enough to provide an opportunity for study. With the enlargement of the Blue Cross programs more patients are under the care of private doctors with the result that ward or service cases are becoming less abundant. The answer may be the plan of permitting house officers to take care of private cases, yet some declare that even should this come about, the house man would never have the feeling of having complete charge of a private case as he does the service case.

Teaching Facilities and Modern Plant

Good teaching facilities are next in importance. The house officer expects his hospital to have a modern x-ray department, an up-to-date, well equipped laboratory, and

WHAT HOSPITAL EXPECTS OF HOUSE STAFF

Earn Respect as a Doctor

One of the first demands that management should make of its house staff is that by word and deed every intern and resident carry himself like a physician. Then the respect due him would come naturally. No doctor should expect to receive the respect due a physician just because he has an M.D. after his name. He receives such respect only if his actions and bearing earn it.

Uphold Professional Ethics

Every young doctor should realize that he is expected to maintain good public relations. Often the long standing excellent reputation of a hospital is damaged by some thoughtless word to an outside physician or to relatives of a patient. Good professional ethics demand that the physician not carelessly criticize the doctor who sent the patient into the hospital. How often have we heard a patient remark that the hospital physician told him: "You arrived at the hospital just in time to save your life." This is often a reflection on the professional work of the referring physician and, in the long run, does not do the hospital's reputation much good. Good patient relations are important. This goes far beyond the room provided for the patient and the type of food served. House officers are expected to treat hospital patients with the same kindness and understanding they would extend to their own patients if they were in private practice.

Maintain Accurate Records

One of the biggest thorns in the side of the administrator is the apparent lack of interest on the part of both the house staff and the attending and consultant

WHAT HOUSE STAFF EXPECTS . . .

a department for research with an opportunity to do some investigative work, no matter how small, for himself. He wants the opportunity to avail himself of all the latest laboratory and x-ray technics.

In this connection, it may be added that a house officer prefers to work in a modern hospital plant with modern equipment. While it is true one cannot judge the quality of medical care by the age and condition of the hospital buildings, all other things being equal, an intern or resident usually feels that he can do better work in an up-to-date hospital than he can in an old physical plant.

Attending and Consulting Staff

The house officer expects good attending and consultant staff men to guide and give him the benefit of their professional experience. Among doctors and laymen alike, most hospitals are judged by the caliber of their attending and consultant staffs. Young physicians take pride in being associated with men prominent in their specialties. In addition, house officers often make lasting contacts with their senior men. For that reason they often choose for their residencies hospitals located in the city where they expect to settle down to practice.

Time for Improvement

A house officer also feels that he should have time off from his regular duties to improve himself both medically and culturally. Young physicians today want free time so that they can take advantage of opportunities to broaden their lives.

Living Wage

A great need of the young physician is for a living wage. Discounting an amount that would compare with tuition for the training given by the hospital, a young man feels that he should have enough to support himself, a wife, and perhaps a child. It is usual today for house officers to be married and in the process of bringing up a family. Along with his stipend the resident or intern expects such fringe benefits as Blue Cross or the equivalent hospitalization and health insurance for his family, uniforms and laundry privileges.

WHAT HOSPITAL EXPECTS . . .

physicians in the matter of administrative or paper work. Medical schools are more and more stressing the fact that a good physician must also maintain accurate and complete records. This is true not only in a hospital, but also in private practice. Increasing numbers of physicians are being called upon to complete forms for Blue Shield, insurance companies, and workmen's compensation. All physicians are beginning to realize that, while their primary purpose is to treat the patient, all treatment, no matter how excellent, suffers when accurate, complete and prompt records are not kept. Doctors' progress notes, operative notes, and discharge summaries are the three items which cause the greatest concern to the administrator. It is the duty of the chief of staff to see to it that all charts are kept current.

Cooperate With Attending Staff

A house officer is expected also to make every effort to work in harmony with the administrative staff. Some house and attending staff men develop the notion that they are prima donnas. Each physician should realize that his is not the only service in the hospital. When funds are available only for a limited number of administrative improvements it is up to the administrator, in consultation with the chief of staff, to determine which service has the higher priority for these improvements. House officers must accept such decisions without feeling that services other than theirs are being favored.

Keep Abreast of Developments

Of course, every hospital expects its house officers, and, in fact, all its doctors, to practice good, sound modern medicine and demands that each physician keep himself abreast of all advances in diagnosis and treatment.

Use Discretion in Ordering

Doctors should be made aware of budget restrictions and cost and should be expected to order supplies and instruments that will be used and not allowed to rust on the shelves. The ordering of drugs is a most important matter in a hospital since it usually represents a sizable expenditure of funds. While every hospital is expected to use the newest drugs available, every resident and staff member is expected, in turn, to order drugs for definite indications. Too often, a doctor insists on the purchase of a quantity of a new drug only to have a large amount of it remain on the pharmacy shelf after the doctor has lost interest in its use. This represents an enormous waste of money. The administrator should expect the chief of staff to screen all expenditures for new drugs and to limit the supply consistent with a reasonably expected use. Some hospitals even set up drug committees for this purpose.

Dr. Leon Ross is manager of the Veterans Administration Hospital at Brecksville, Ohio. Before assuming this post last year, Dr. Ross was director of professional services at the V.A. Hospital in Cleveland for 10 years, where a training program was carried out for residents affiliated with Western Reserve University School of Medicine. Dr. Ross received his M.D. degree from New York University; he was in private practice before joining the V.A. in 1942.

ABOUT PEOPLE

Administrators


Ernest I. Erickson

Ernest I. Erickson, administrator of Augustana Hospital, Chicago, since 1923, has announced his retirement. He will continue to serve as a consultant to the hospital's building program, scheduled for completion late next year. **Martin H. Hough,** assistant administrator for the last 10 years, will succeed Mr. Erickson; he is a member of the American College of Hospital Administrators. During his hospital career, Mr. Erickson has been active in many organizations. He is a charter fellow of the A.C.H.A., and has served as its president and as a regent. He is a trustee of the Chicago Blue Cross plan, and a former trustee of the Chicago Hospital Council. He has held the presidency of the American Protestant Hospital Association, the Lutheran Hospital Association, the Illinois Hospital Association, and the former Chicago Hospital Association.

Franklin P. Iams has been appointed administrator of the proposed 300 bed Fairfax Hospital, Fairfax County, Va., effective July 1. Mr. Iams has been administrator of University Hospital of New York University-Bellevue Medical Center since July 1956. Prior to his New York post he was assistant director of Rhode Island Hospital, Providence. Mr. Iams received his master's degree in hospital administration from the University of Minnesota, and is a fellow of the American College of Hospital Administrators.

George A. Miller, assistant administrator of Monmouth Memorial Hospital, Long Branch, N.J., has been named assistant executive director of Unity Hospital, Brooklyn, N.Y. Mr. Miller, who has been assistant administrator at the New Jersey hospital for two years, and administrative resident for one year, received his master's degree in hospital administration from the University of Toronto. He will be succeeded by **Burton M. Gottlieb,** who has been administrative assistant at the hospital since June 1957. Mr. Gottlieb studied hospital administration in the graduate school of public health at the University of Pittsburgh.

Clifford G. Sawyer, director of Babies' Hospital, Newark, N.J., for the last five years, has been appointed administrator of Booth Memorial Hospital, Flushing, N.Y. Before going to Babies' Hospital, Mr. Sawyer was director of Memorial Hospital of Bedford County, Everett, Pa.

Robert E. Fore, administrative assistant at Baptist Memorial Hospital, Memphis, Tenn., since 1956, has been appointed assistant administrator of Georgia Baptist Hospital, Atlanta, succeeding **Ben Brewer.** Mr. Brewer's appointment as administrator of West Kentucky Baptist Hospital, Paducah, was reported in the May issue of The MODERN HOSPITAL. Mr. Fore received his master's degree in hospital administration from the University of Minnesota, and served his administrative residency at the Memphis institution.

William J. Derevlany, assistant administrator of Jamaica Hospital, Jamaica, N.Y., has been named assistant administrator of Waterbury Hospital, Waterbury, Conn.

William J. Skerry has been named administrator of Somerville Hospital, Somerville, Mass. A graduate of the St. Louis University course in hospital administration, Mr. Skerry has held the post of assistant director at Malden Hospital, Malden, Mass., for the last two years.

Don McGrath, administrator of LaFollette Community Hospital, LaFollette, Tenn., has been appointed administrator of Children's Hospital, Knoxville, Tenn., succeeding **William J. Stout.** Mr. McGrath is a graduate of Duke University's hospital administration program, and served as administrator of North Carolina Cerebral Palsy Hospital, Durham, a state agency operated under the department of orthopedics at Duke.

Thomas J. Paden has been appointed administrator of Citizens General Hospital, New Kensington, Pa., succeeding **Thomas B. Fitzpatrick.** Mr. Fitzpatrick, who has been at the hospital for the last four years, recently accepted a research post at the University of Michigan. Mr. Paden, a graduate of the hospital administration program at the University of Pittsburgh, was formerly administrator of Memorial Hospital of Bedford County, Everett, Pa.

Poerner Riehl has been appointed administrator of Polly Ryan Hospital, Richmond, Tex. Mr. Riehl, a graduate of Northwestern University's hospital administration course, recently completed his administrative residency at Baptist Memorial Hospital, Houston.


Philip J. Walsh

Philip J. Walsh has been appointed assistant vice president (institutional) of Roosevelt Hospital, New York, succeeding **Richard H. Ward,** who resigned recently. Mr. Walsh previously was administrator of Eastern New York Orthopedic Hospital, Schenectady, N.Y. He also served as assistant director of Elizabeth General Hospital and Dispensary, Elizabeth, N.J., and as director of Newcomb Hospital, Vineland, N.J. He is a graduate of Northwestern's hospital administration program.

John C. Barker, assistant director of Maine Medical Center, Portland, has been appointed acting director, following the departure of **Donald M. Rosenberger** to assume his post as head of the new medical center at Newark, N.J.

Frank L. Porter has been named administrator of Shore Memorial Hospital, Somers Point, N.J. Before joining the hospital staff in October 1956 as assistant administrator, Mr. Porter was assistant director of University Hospital and Hillman Clinics, Birmingham, Ala. He received his master's degree in hospital administration from Columbia University. Mr. Porter succeeds **Dr. Irving E. Braverman,** administrator since 1952, who resigned to enter private practice.

Dr. Alfred C. LaBoccetta, medical director of Philadelphia General Hospital, Philadelphia, has been named acting executive director of the hospital. **Dr. F. Lloyd Mussells,** former executive director, has assumed his new post as director of Peter Bent Brigham Hospital in Boston.

Charles R. Goulet has been appointed associate director of Johns Hopkins Hospital, Baltimore, effective July 1. It was previously announced that Mr. Goulet would become assistant director of the hospital. He holds the position of assistant professor of hospital and medical administration in the graduate school of public health at the University of Pittsburgh. Before going to Pittsburgh, Mr. Goulet was assistant superintendent of Cleveland City Hospital, Cleveland. He is a graduate of the University of Chicago hospital administration course and a member of the American College of Hospital Administrators.

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Two ways of improving your purchases

Standardization committees and value analysis are two prime aids in getting the right materials at the best price into the hands of those who will have to use them

Vincent W. Godlesky

INDUSTRIAL purchasing departments have demonstrated to management that, by using modern tools of purchasing, they could lower the costs of materials and equipment and assist in the development of better products. With the same tools, hospital purchasing departments can and should demonstrate that they can assist in producing better patient care at lower cost.

What are the modern purchasing tools that have been found so effective? Among these tools can be listed standardization, value analysis, and many others.

Let's take a look at *standardization*, for example, to see what it is and whether it has any inherent advantages for us. It's not a new or fancy word, but it is currently an important subject in the purchasing field.

There are almost as many concepts of standardization as there are actual printed standards, but I believe the following serves as a comprehensive definition:

In the National Association of Purchasing Agents' Standardization Manual, standardization is considered "the organized process of obtaining solutions to common problems." Thus, it can be said that standardization is the criterion established by common consent.

How helpful it would be to purchasing agents and to personnel to have a way to solve their problems of getting the right things for given purposes. Many industries have this facility, and some hospitals have it now. All hospitals can have it by developing a standardization program.

In some cases, this may merely mean making a formal program of what we are now doing through close contact with other departments and through committees.

Organizing standardization committees is not always as easy as it may sound because it requires the time of a number of people. Time is scarce in a hospital, and, furthermore, it is difficult to convene two or more people at a given time.

However, where it can be done, I am convinced that the effects will be rewarding to all concerned. At Beth Israel Hospital, Boston, we have five active standardization committees, covering the following categories of supplies: medical and surgical, laboratory, dietary, textiles and uniforms, and stationery and office supplies, including forms.

The committees are comprised of members of the administration, doctors, nurses, department heads, and other key people whose experience qualifies them to help evaluate certain items used in their areas. The purchasing agent and his assistant are members of each committee. The general director of the hospital is not only keenly interested in the activities of these committees (he receives copies of the minutes of all meetings), but he is also the chairman of one of them. Getting administration and the professional services to participate in standardization programs and in purchasing decisions is certainly a great step toward obtaining the recognition for which hospital purchasing has been striving.

We have found that participants in standardization committees appreciate the opportunity to evaluate items before they are included as standard items of issue. And they are gratified that their advice is solicited and that their opinions are given weight in final decisions.

What are the objectives of a standardization committee? The primary one is to get a consensus of what product is best or most suitable for as long as can be foreseen. Such determinations and recommendations can best be made with the assistance of the people who actually use the things bought for them. For example, how can a purchasing agent alone be expected to determine the most suitable qualities for a catheter, a surgical dressing, or a suture material?

Although many of us purchase and reorder those and many other items routinely, how certain are we that we are buying the most suitable products available unless we constantly confer with the users, periodically review, and, if necessary, revise our specifications? Periodic review is a healthy habit, to be sure. But com-

Condensed from a paper presented at the New England Hospital Assembly, Boston, 1958.

Vincent W. Godlesky is purchasing agent and assistant in administration at Beth Israel Hospital, Boston. He took a temporary job as storekeeper at the hospital in 1932, and has been there ever since, receiving the title of purchasing agent in 1939. He has served on the faculty of A.H.A. purchasing, nursing and dietary institutes, and has lectured on purchasing at Boston University. Mr. Godlesky has worked on the boards of directors of the New England Purchasing Agents Association and the Hospital Purchasing Corporation of Boston. Several of his papers have been published in hospital journals.

bined foresight, planning and action are better.

To keep current with the increasing development of new products and with the increasing number of prepackaged and presterilized items, the hospital purchasing agent needs plenty of help, not only in evaluating products per se, but in some cases to pass judgment on the structure and other characteristics of the package to make certain that it lends itself to hospital technics. This is where a standardization committee can play an important rôle that will benefit the patient, the doctor, the nurse, the purchasing agent, and, we always hope, the budget.

Through standardization committees, we can make the greatest use of the able assistance that is always available in other departments. I am certain that we all recognize the advisability of consulting with individual department heads, supervisors and other key people in evaluating some products, and I am sure that we all avail ourselves of their valuable assistance. However, unless this is done on an interdepartmental team or committee basis, to which the administration has given authority for decisions, one important objective of standardization will not always be achieved, that is, a consensus of everyone concerned that the products selected are the best for everyone.

The standardization committee procedure licks those disturbing problems of communication, coordination and conflicting views. Most important, however, is that usually it gets results that satisfy everyone.

Another tool of purchasing is *value analysis*. Although it is closely related to standardization, it is definitely concerned primarily with price structure and cost reduction. According to information from industrial purchasing departments, value analysis is replacing the competitive bid system in some areas of their purchasing in which it eliminates much paper work and time.

This technic of value analysis seems to be what we in purchasing have always been doing, *i.e.* applying our knowledge to obtain value, value being simply the most in quality for the least in price.

Value analysis is broadly described as the process of eliminating unnecessary costs from products that are bought. In other words, it is eliminating features that add to the cost but contribute nothing to the utility of the product.

How can we do this?

Before placing orders we should not be satisfied with having only basic specifications of the items we are about to buy, such as style, type, grade, size, weight, color and so on. We should also ask ourselves, and the users, such questions as:

What is the intended use of the item?

Is there anything better for the intended use?

Is there a suitable substitute available?

Can a standard product be found which will be usable?

Does it need all of its features?

Is the cost proportionate to its usefulness?

Will other dependable suppliers provide it for less?

Is anyone buying it for less?

Are there transportation costs?

Those are the types of questions that aid value analysis and value purchasing, and we should use them to make certain that we are buying the most suitable products at the lowest available cost.

The value analysis approach is applicable to virtually everything we buy, and probably to a greater degree today than before, since today there are many new products designed to replace conventional hospital items that have been in use for a long time without change.

Some of these new products are: interchangeable syringes, disposable syringes, disposable needles, paper wraps, plastic suture containers, presterilized items, peeled potatoes, and prepackaged salt.

Just as hospitals once evaluated stainless steel in relation to enamelware, and the various forms of plastic in relation to china, glass and rubber, and then decided that, in many cases, the new materials were a better value, so we must be prepared to apply value analysis technics to all new items to determine whether they are better values than those we are now buying.

Value analysis is an excellent tool for reducing costs, obtaining maximum values, and providing personnel with better equipment and supplies.

To apply this tool effectively, we should, as with standardization, invite the cooperation of other people.

To Learn About Purchasing—Take a Walk

HOSPITAL purchasing agents are in a unique position to express their views and to participate in many decisions about the types of supplies and equipment that are purchased for use by many other people in the hospital. As purchasing agents, therefore, we should control our egos and be careful that we don't create the impression that only we are qualified to evaluate everything we buy.

If any purchasing agent does have such an idea, I would advise him to take a long, leisurely walk through departments of his hospital to see and to learn, from the users, just how effective his purchases are in relation to the purposes for which they were made.

I dare say he will be in for a few surprises and will probably come back enlightened if not deflated. Experience has convinced me that no one individual, not even the purchasing agent, is in a position to know what is best, what is most suitable, or even most economical, for a given purpose. And I dare say this holds true in all hospitals—small or large.

It has been said that the buyer is supposed to know more about purchasing than any other person in his organization. But let the buyer beware who believes that to the point of conceit. The buyer should find that elusive degree between self-confidence and conceit and, with that knowledge, cooperate. Cooperate with everyone in the hospital.

Consult the people whose hospital experience qualifies them to help evaluate not only the utility of the increasing number of important and complex pieces of equipment, but also the time and labor saving factors involved.

Both of these mean money, and must be considered in determining the ultimate value of the things we buy.

Who but those with using experience can help us estimate how much time and labor might be saved and also assist us in translating those savings into financial savings or reductions in operating costs?

The sooner we recognize and use the assistance that is available to us in our hospitals, whether it be committees, individual consultations, or joint interviews with users and salesmen, the sooner we will find ourselves fulfilling our major responsibilities of bringing about cost reductions and doing better buying for better care.

Basil C. MacLean, M.D.

Public moves in on Blue Cross

MANY Americans said 25 years ago that government health insurance was the only way hospital care could be financed. Others were saying then that any government step toward paying for health care was a step toward socialism and evil. The insurance companies labeled the whole business "actuarially unsound." While they all argued, the hospitals quietly set up what is now known the world over as Blue Cross.

When the insurance companies saw that the Blue Cross idea was going to work, they were quick to enter the field of hospital–and later medical–insurance. Other types of prepayment plans also sprang up around the country. Through these different–but all voluntary–approaches, we have seen the broad application of the social insurance principle to financing health care. America has found over the last quarter century that health is purchasable. What seemed to many like an "Alice in Wonderland" idea has become reality.

The accomplishments of voluntary prepayment, and particularly of the pioneer, Blue Cross, are many. The focus today has to be on what is still to be done, not on the job done in the past. The people who brought health care financing "Through the Looking Glass" can't stop there. Voluntary prepayment still has farther to go, and the public that has come to depend on prepayment is aware of how far it has to go. There's evidence of this, I think, in the public hearings that have been held this year, chiefly on requested rate increases, in about one out of every five states. Before the end of the year undoubtedly there are going to be more of these public reviews.

Presented at the Association of Western Hospitals convention, San Francisco, April 1958.

Dr. MacLean is president of the Blue Cross Association, New York.

There is a feeling in some quarters, that Blue Cross is being hurt or at least threatened by these hearings. I have followed those which have been held in eastern states, and I don't agree. I believe the public has attained a better knowledge of the day-to-day operations of Blue Cross–a knowledge of the day-to-day operations of Blue Cross–a knowledge, of course, to which people are entitled. I see nothing to fear in publicity. The press reports can only help, particularly if they spell Blue Cross correctly and in capital letters.

In several states commissioners of insurance and others have asked for legislative commissions to inquire into various aspects of prepayment mechanisms. There is nothing in our program which could be hurt by these studies, but I must point out that a persistent question is raised about whether Blue Cross payments to hospitals are based on cost of services provided or whether uncontrolled or unnegotiated charges are paid. It is felt also that the Blue Cross subscriber should not be called upon to meet, in addition, the cost of care of indigent and part-pay patients or, under some mystical research program, the cost of finding the calcium content of a rat's tail.

These questions aside, Blue Cross cannot be hurt by greater public understanding of what it does. Hearings and commissions can only make it clearer that Blue Cross has a unique ability to meet the public's demand for continued health care progress. This ability, like its past successes, is the result of a unique quality of Blue Cross. Every Blue Cross plan is a local plan established to serve the public by providing a means for all members of the community to finance their health care needs. This is the concept on which Blue Cross success was built. I don't want to imply that it has been adhered to equally by all of the plans at all times. But where this idea has been most strictly adhered to, Blue Cross has had its greatest growth. And the plans that have embraced the idea fully have served their communities better.

I venture to say to my friends in hospitals some things which may be more practical than popular, and I do so because of more than 25 years in hospital administration and as a midwife of one of the earliest hospital insurance plans in 1932 which is now one of 80-odd Blue Cross plans. Some of you perhaps can recall the strain on hospital operation and finance in the depression days of the early Thirties. Commercial health insurance was small and puny. Accounts receivable were so high and cash so low that a payroll date often had the gloomy forebodings of a farm foreclosure sale. Then came the child of hospital parentage which has grown to be the cash register of all the hospitals in the United States. I am puzzled a bit when I hear that some people think apples bought by the carload should not have some differential in price from those bought by the basket.

As big a carload buyer as Blue Cross is today, it still does not reach all members of the community. One of its objectives, therefore, is extending enrollment to all of our population. At the local level, extending enrollment means reaching particularly people who can't be enrolled in employe groups. This nongroup population is a big one–an estimated 55 to 60 million people. It includes the self-employed, unemployed and retired people, farmers, and people who work where there are too few to form a group.

It is clear that a number of these

nongroup segments can be reached by increased effort and improved enrollment technics. Some Blue Cross plans have already found ways to reach the self-employed, for example. For some of the other nongroup people, the enrollment prospects are not as clear. Satisfactory mechanisms for covering the indigent, the unemployed, and the aged have not yet been developed.

During the last two years there has been a rash of conferences and commissions, reams of published material, on financing health care for the aged. It seems likely that this active interest will result in legislation, federally and in states, within the next few years. Fortunately, Blue Cross, unlike most commercial insurance companies, has not conspired against our senior citizens by using the age of 65 as a contract escape point. Instead, Blue Cross has a long established policy of continuing its oldsters as individuals or as retirees of groups.

Some consideration is being given now to covering the aged under the federal social security program. Without endorsing any one of the specific proposals for governmental financing of health care of the aged, I do want to point out that the blanket opposition of a few groups to *all* of them—without constructive alternatives—will not solve this pressing problem. I

THE KEY TO PRESERVING THE VOLUNTARY HEALTH INSURANCE PRINCIPLE

George Bugbee

THE largest group of people who have trouble paying their hospital bills when they are ill, or who avoid hospitals because they are unable to pay for care, are the most difficult to enroll in voluntary health insurance because they are not employed in a group. Hospitals and voluntary health insurance agencies must devote greater effort to enrolling this nongroup population. The successful solution for enrolling these individuals and their families from the nongroup population must be found and broadly applied if voluntary health insurance is to remain a satisfactory solution to the problem of financing hospital care.

Voluntary health insurance has grown largely by the enrollment of employe groups. Coverage of people who can't be enrolled through their place of employment—the nongroup population—has lagged far behind. In addition, the benefits available to nongroup subscribers are generally lower and the cost of protection is higher than they are for subscribers with group contracts.

Enrolling groups of people working for a common employer has obvious advantages. A single contract obtains a large number of members, whose premiums can be obtained conveniently by automatic payroll deductions. Moreover, enrolling large groups minimizes the chances of any disproportionate number of adverse health "risks." Enrolling and covering individuals, on the other hand, can be complicated, time consuming, and expensive.

Enrolling the nongroup population, however, is essential to continued growth of voluntary health insurance. The nongroup forms an estimated one-third of our total population, and it contains such large and important parts of the population as farmers and rural workers, the self-employed, the aged and retired, and those who work where too few people are employed for group coverage.

Some Blue Cross plans have, of course, accomplished a great deal in enrolling some of these nongroup segments. Insurance companies also have enrolled many and, in the past few years, many of the "old-line" companies have entered the field, bringing the resources of their many agents across the country. To aid all health insurance agencies in extending nongroup enrollment and increasing nongroup benefits, Health Information Foundation recently financed and conducted a research study to analyze the experiences and problems of those enrolling this population.[1] While this study focused on the efforts of Blue Cross hospitalization plans, its findings should encourage much more activity by all enrolling agencies.

Of the 43.5 million Blue Cross subscribers in the United States at the end of 1954, the last full year before the study, 32.2 million were enrolled through employe groups. Almost 6.6 million more were former group members who had retained their coverage. Only 4.8 million people were enrolled as nongroup members. Blue Cross had therefore enrolled about one-third of the estimated 99 million people forming the group population, but less than 9 per cent of the 56 million people in the nongroup population.

Progress has been made in enrolling the nongroup population since 1954, but the disparity in enrollment results is still great. At the beginning of 1958 some 123 million people (71.6 per cent of the total population of 171,971,000) had some health insurance coverage. The nongroup, estimated at 34.9 per cent of the population, contained about 60 million people. Of these, 64.9 per cent had coverage—including those who retained their coverage when they left an enrolled group. Of the 106,416,000 people employed in groups (other than those in the armed forces or institutions) 79 per cent had some coverage.

Private companies have been more effective than Blue Cross has in reaching and enrolling the nongroup population. They cover about twice as many nongroup subscribers as Blue Cross does on a national level, and they exceed Blue Cross by a much greater percentage in some areas. In the South, for example, they provide 85 per cent of the nongroup coverage. Private companies also cover a greater proportion of older nongroup people and people with incomes below $2000—both sizable segments of the nongroup population.

Despite the superior numerical results they have achieved, there is greater disparity in the level of benefits between group and nongroup members enrolled by insurance companies. The insurance companies have offered the nongroup relatively low benefit levels, and enrollment costs to pay for aggressive selling undoubtedly have been and are one explanation of the benefit level. However, the enrollment results have been substantial. Blue Cross plans have offered higher benefit levels, but their results in the number of the nongroup people covered often have been unimpressive.

Even among Blue Cross plans, nongroup subscribers receive significantly lower levels of benefits than do group

Mr. Bugbee is president, Health Information Foundation, New York.

[1] Levine, Sol; Anderson, Odin W., and Gordon, Gerald: Non-Group Enrollment for Health Insurance: A Study of Administrative Approaches of Blue Cross Plans. Cambridge, Mass.: Harvard University Press, 1957.

think we must concede that government has a legitimate interest in seeing that the health needs of the aged are met.

Increased enrollment locally will continue to be a key objective of Blue Cross plans—and the most important way, in my opinion, that Blue Cross can grow. But extending Blue Cross enrollment nationally provides a second important way for Blue Cross to obtain its enrollment objectives.

As you know, the Blue Cross Association was reorganized less than two years ago to facilitate national enrollment. A Blue Cross Association was needed because the separate plans could not cope effectively with program planning and enrollment needs beyond their own plan areas. When unions and management began to put health care into their employe benefit programs, and when collective bargaining moved from the plant level to company-wide negotiations, with an inevitable demand for uniformity in all areas, Blue Cross had to develop an effective means for national enrollment. The Blue Cross Association is the instrument that emerged.

Essentially, the Blue Cross Association is a voluntary association of plans that have agreed to underwrite national enrollment programs with their own contracts. The plans' agreement to cooperate on national contracts

LIES IN FINDING SOME WAY OF ENROLLING THE NONGROUP POPULATION

members. Seventy-nine of the 85 Blue Cross plans enroll members on a nongroup as well as a group basis. Of these, 50 treat the nongroup less favorably with regard to age limit provisions, 21 provide fewer days of coverage, and 16 permanently exclude conditions that are not excluded in their commonest group policy. Other provisions—waiting periods, maternity benefits, and the like—similarly favor group members.

If the nongroup subscriber's illness is not excluded by any of the provisions of his contract, he does have almost the same proportion of his hospital bill paid by Blue Cross as does the group subscriber. (On the average, Blue Cross paid 77.2 per cent of the bill for patients covered by group contracts and 75.2 per cent of the bill for those with nongroup contracts.) However, the cost of this comparable protection is much higher for nongroup members. The average cost per dollar of daily protection (the annual premium divided by the average daily expenses covered by the contract) is $1.41 for group members. Because of their higher premium rates, it is $1.80 for nongroup members—28 per cent more.

Although a few plans have enrolled more than half of their nongroup populations, most have made much less progress. Only half of the plans have enrolled as much as 10 per cent of the estimated nongroup population in their areas, and only a fifth have enrolled 20 per cent.

The greatest barrier to enrolling the nongroup population, according to 50 per cent of the Blue Cross administrators themselves, is the difficulty of reaching this population. Of the various segments of the nongroup, the rural farmer is considered the most difficult to reach.

Other barriers regarded as most important by a number of plan administrators include: insufficient knowledge about Blue Cross by the nongroup population, the cost of protection, the difficulty in obtaining an adequate cross section of the population, and the cost of acquiring members.

The difficulty in reaching nongroup members and the cost of acquiring them as members are naturally related. There are no exact figures on the cost of acquiring either group or nongroup members. However, estimates by the plans indicate that the cost of acquiring the nongroup member is appreciably higher, as would be expected. While close to 40 per cent of the plan administrators made no estimate of acquisition cost, 35 per cent estimated that the cost of acquiring a nongroup member was more than $4 (only 16 per cent estimated the cost of acquiring a group member to be that high).

The need for obtaining a representative cross section of the population in nongroup enrollment is related to the fear of the plans that a higher proportion of poor risks obtain hospitalization insurance when it is offered to individuals. This results in higher utilization rates by nongroup members—and higher costs to the plans.

As reported by 54 plans that recorded utilization data for their group subscribers, these members had an average utilization rate (of days of care per one thousand members) of 860 days. Nongroup subscribers (reported by 49 plans) had an average rate of 947 days. Members of the "left employ" group (reported by 47 plans) had the highest average rate: 1090 days.[2]

[2]These rates represent actual use within the different underwriting controls that exist for each group, not the pattern of use that would exist if contract provisions were the same for all three groups. The utilization rate of nongroup members would undoubtedly be higher if they were not subject to various underwriting provisions. Group conversion members, on the other hand, would show a lower rate if they were subject to the same controls.

Legal factors do not seem an important barrier to nongroup enrollment. However, legislation and the policies of insurance commissioners in some states have affected a few plans. With respect to nongroup enrollment, the most important area of jurisdiction over Blue Cross is the policy of the insurance commissioner toward pooling different population segments. A few commissioners, by insisting that no population group be subsidized by another, have prevented plans from pooling subscribers enrolled individually with the rest of their membership.

To meet the higher acquisition cost and higher utilization rate of nongroup enrollment, Blue Cross plans use higher premiums, waiting periods and exclusions, more rigid age limits, and the like. In addition, many plan administrators have considered other mechanisms less widely used. Chief among these have been enrollment fees, deductible provisions, and, related to deductibles, coinsurance provisions.

Enrollment fees—usually a dollar or two charged when the individual enrolls—are intended to meet the higher acquisition cost of nongroup enrollment. Some 23 Blue Cross plans use an enrollment fee for nongroup members or for both nongroup and group members. Eighteen of these plans favor the group members in setting this charge, or use it only for nongroup enrollees.

Among all the plans, about half (48 per cent) of the administrators feel that an enrollment fee is neither necessary nor desirable. Twenty-seven per cent regard it as both, however, while the remainder feel that it is either desirable but not necessary (11 per cent) or necessary although not desirable (14 per cent).

Deductible provisions, in which the

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allows Blue Cross, for the first time, to work out a program with a large national employer or union and know in advance that it can deliver the particular coverage that evolves. When the association has implemented fully the program laid out for it, Blue Cross will be able to function nationally with management and labor with the confidence that comes from knowing that what is said can be done.

This national development is important in fulfilling Blue Cross local community functions. The national account is only *enrolled* nationally, usually of course, through the efforts of individual plans. It is still the local Blue Cross plan that provides the coverage for these people who are members of the plan's own community group.

Important as local and national enrollment growth are, they are not the only Blue Cross objectives. It is equally vital that Blue Cross improve the benefits of the people it already protects. Here, because the level of development among the Blue Cross plans differs, it is difficult to talk about *immediate* benefit goals. Some plans will be able to strengthen benefits—and cover an expanding scope of health services—faster than will others.

It is evident, I think, that the public is prepared to pay for more inclusive health care. The "major medical" package offered by commercial insurance companies is being bought by more accounts. It now covers about 13 million people in industrial groups. In some aspects it is inflationary, but its success indicates a need. On our own side, we are developing a complete hospital care contract, which I like to call the "Lifeguard Contract" which will be sold to national accounts and which could be serviced by all Blue Cross plans.

BATTLE OVER SERVICES

One stumbling block against efforts to provide hospital care by prepayment is the battle to remove from Blue Cross contracts in some parts of the country traditional hospital services like radiology, pathology and anesthesia. If we are to think of health service as a goal in a package sense, the hospital operation should not be as confusing to Joe Blow as the store where in buying a suit he had to pay for the coat in one place, the pants in another, the buttons in another, and even the buttonholes to another tailor. Long established practices of hospitals have come under attack as constituting the illegal corporate practice of medicine, despite the opinion of the general counsel of the American Hospital Association that the law should not "interfere with the operation of nonprofit hospitals in whatever manner may be conducive to the welfare of their patients." As he has stated, "Coordinating the great variety of professional and nonprofessional services in the modern hospital would be all but impossible if each professional participant were required to be an independent entrepreneur."

But the near future—the next five years, in all probability—should see a far higher prevailing standard of benefits among the plans. I see that standard including provisions for preventive, diagnostic and rehabilitation services provided by hospital outpatient departments, and benefits for long-term illness, convalescent care, home nursing, and the like. I think we can say that the benefit goals of Blue Cross are broader still. There is no reason, for example, why all general hospital admissions, regardless of the reason for admission, should not be fully covered by prepayment for whatever period of hospital stay is medically indicated. The public desires and can pay for this standard of protection.

In speaking of expanding enrollment and benefits, I have mentioned only Blue Cross. Obviously, though, Blue Cross can never be more than the *agency* for prepayment—the hospitals must provide the services, the physicians must determine medical need and provide treatment. The relationship of Blue Cross to hospitals, physicians and the public will therefore decide in large part how soon Blue Cross achieves its goals.

Broadened benefits and the enrollment of groups without regard to their use of health care are Blue Cross objectives I have already mentioned. But these must be paid for. With costs rising for present services and levels of use increasing as well, the public will have to allocate much greater amounts to health care to gain any consistent increases in benefits. The public wants to feel that, year to year, the level of protection enjoyed against health care costs is being strengthened. At the same time, the public wants to know that hospitals, physicians and prepayment plan officials are developing better methods for providing care and for the payment of services. Ways for doing a better job cheaper must be explored. The blank check system of payment is sure to end and there is an insistent clamor for controls. If controls are not provided the public will say "A plague on both your houses" and government will be asked to take over.

We know from recent statistics, for example, that the rate of hospital admissions is reduced if prepayment covers outpatient services. It therefore does not make sense to cover only costly in-hospital care, which appears to encourage use, for services that can be provided less expensively in the hospital's outpatient department. It is sensible to provide as much as possible on the hoof instead of between hospital bed sheets.

Prepayment plans and hospitals must also discourage benefits which raise the total cost of health care to the public, and encourage those benefits which will lower the cost. Wherever a hospital council exists, with influence on public opinion, there is less danger of hospital beds becoming as excessive as the present motor car inventories.

Similarly, controls on marginal or unnecessary use of health services rest primarily with the hospital and the doctor, not the patient. Controls cannot fairly be applied by denying benefits or by imposing economic barriers to care.

The image of Blue Cross in the public mind must be made essentially the *same* picture throughout the country. To make this so, we will have to affirm our support of the common objectives of Blue Cross and then inform the public of these objectives.

BRING COMMUNITIES CLOSER

The communities in which each plan operates will have to be brought into a closer partnership in setting Blue Cross policy and objectives. If any single task that Blue Cross faces can be termed the most urgent, it is this one.

For example, it is frequently charged that Blue Cross boards are silk-stocking, self-perpetuating hierarchies. That's not generally true, but it *is* true that most boards have far too little representation of important consumer groups. We can't continue to ignore what management and organized labor contribute to Blue Cross enrollment and support.

Hospitals, I would say, should not have more than one-third of the membership on Blue Cross governing boards, in accordance with American Hospital Association standard of approval number one. That would mean a more reasonable balance between the buyers and the sellers of our product and remove much of the suspicion that Blue Cross to hospitals must "dance attendance to their Lordships' pleasure." We'll make progress faster if together we can point the social concept of this movement.

Do you remember that at one point in Lewis Carroll's "Through the Looking Glass," the Red Queen seized Alice by the hand and ran rapidly—for they agreed that one had to run fast to stay in the same place, and at least twice that fast to get anywhere. That's where we are today. #

There are 71 ways an employe can steal, and when the management is careless in handling funds it can expect to be robbed. In this article the authors explain how

Cash Controls Keep Employes Honest

Charles T. Lotreck and Frederick C. Morgan

MOST human beings are subject to various weaknesses: mistakes, carelessness, forgetfulness, indifference, laziness and temptation, but of all of these, temptation causes the greatest loss in business.

Bonding companies state that 25 per cent of all people bonded are honest, 25 per cent are dishonest, and 50 per cent are just as honest as they are forced to be by the system under which they work. A sound system of internal control is a powerful deterrent to the 25 per cent inherently dishonest people and can remove the temptation factor from the 50 per cent of questionable honesty.

When times improve, embezzlers get bolder. As our gross national income rises into the hundreds of billions, the amounts stolen also rise. Conservative estimates indicate that dishonest employes cost business at least $500 to $600 million annually and probably untold and unknown millions more. Dishonesty claims to fidelity insurance companies have risen 400 per cent in 10 years. These companies are now processing 50,000 embezzlement claims annually. Most embezzlers are men, but since World War II four times as many women are involved as were previously.

Employes are often tempted to take what is not theirs because management appears to have a carefree, nonchalant attitude about its funds. Too often, audits either are done superficially or are bypassed altogether. Management is reluctant to publicize larcenous practices for fear it may encourage other employes to steal. In some instances, management has failed to bond employes who handle cash until the firm has suffered heavy losses.

One surety company estimates there are 71 different ways an employe can steal. The five most common methods applicable to hospitals are:

1. Paying bills to nonexistent companies, then forging signatures and cashing checks.
2. Adding ciphers or figures to checks, invoices and vouchers after they have been approved.
3. Collecting overdue, doubtful accounts or bad debts, but listing them as noncollectible.
4. Adding "ghosts" to the payroll or padding payrolls by increasing time records.
5. Lapping, wherein the cashier diverts payments from a patient's account to himself and then juggles other income to this account from payments made for another patient.

An adage well worth remembering is: "What one end of the pencil writes . . . either end can change."

A survey of 100 embezzlement cases showed that 36 per cent of the frauds were discovered by fortuitous circumstances, or just plain luck; 29 per cent were uncovered by public accountants and internal auditors; 16 per cent by managerial inquiries; 11 per cent by internal checks, and 8 per cent by miscellaneous means.

It is significant that most of the embezzlements studied had been made by diverting cash receipts and disbursements. It is evident, therefore, that the greatest control measures should be exercised where cash is involved.

Internal control usually is defined as a plan of organization incorporating all the coordinate methods and measures established within a business to protect its assets, promote operating efficiency, check the accuracy and reliability of the accounting data, and encourage compliance to prescribed policies.

The principles of a good system of internal control should embrace an organizational plan that provides appropriate segregation of functional responsibilities. There must be authorization and record procedures ade-

In the concluding article, to be presented in August, a system of checks and balances and a process flow for cash after it reaches the business office will be discussed.

Charles T. Lotreck (left) is the assistant director of Genesee Hospital, Rochester, N.Y., a position he has held since 1953. Mr. Lotreck, a hospital administration graduate of the State University of Iowa, is president and former secretary of the Rochester Hospital Forum and secretary of the administrators' conference of the Rochester Regional Hospital Council. Frederick C. Morgan (right) has been controller of Genesee Hospital for the last 10 years. He is a life member of the American Association of Hospital Accountants and served as the group's secretary-treasurer for six years. Mr. Morgan is the author of a textbook, "Office Management and Methods," and originated a course in that subject at Rochester Institute of Technology, where he taught for a number of years. He is a graduate member of the International Accountants Society.

quate to provide reasonable accounting control over revenues, expenses, assets and liabilities. It is important that the quality of persons employed be commensurate with their responsibilities.

In drawing up the plan of organization, care must be exercised so that no person will have complete control over all phases of any significant transaction. Work should flow from one employe to another, so that the work of the second, without duplicating that of the first, provides a check upon it. The plan should provide separation of record keeping from operations or the handling and custody of assets. Wherever possible, physical and mechanical facilities should be included to ensure accuracy and security.

When working specifically on steps to control cash, the following may serve as a check list:

1. Limit to as few as possible the people having access to cash.
2. Delegate and assign to one person the responsibility for each fund and make sure that he understands his specific responsibility.
3. Cover every employe who has access to cash funds with a bond commensurate with the amount handled by that employe.
4. Insofar as practical, separate the custody of cash balances from the task of record keeping and accounting.
5. Provide for intermittent reviews and examinations of balances by persons who don't handle or record cash.
6. Hold cash kept within the institution to a minimum, using banks as custodians.
7. Provide physical protection for funds with such facilities as cashiers' cages, locked and bolted down cash boxes, registers and safes.

In establishing the system of control at Genesee Hospital, Rochester, N.Y., this check list was used as a guide. Also, particular care was exercised to safeguard the operations against the five most common methods of stealing previously mentioned. The accompanying chart was prepared so that a visual examination of the various controls and their locations could be made. Full recognition was given to the possibility of some unforeseen weaknesses in the system that time may confirm.

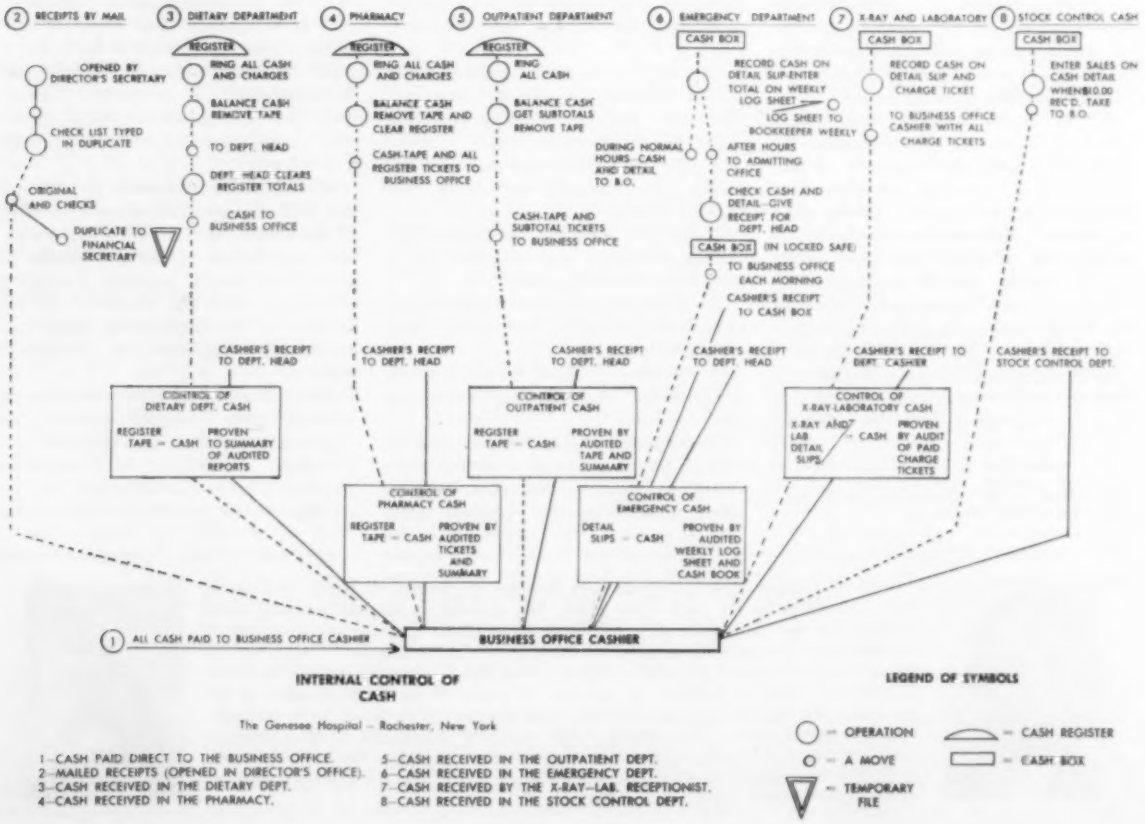
The symbols used in the process flow chart are, for the most part, commonly used in time and motion studies. Some liberties have been taken, however, in an effort to present certain details. Dotted lines indicate the flow to or within the business office. Solid lines illustrate the return of the certified cash register receipts from the business office cashier to the department heads.

The primary sources of cash where control must be stressed are: the business office, employes' cafeteria, pharmacy, outpatient clinic, emergency department, x-ray and laboratory (private ambulatory services), and the stock control department.

Revising existing procedures to assure efficient control of cash presents many problems. We found that, in some instances, the creation of charge tickets was so closely related to the handling of cash that it became necessary to review such procedures as well as the cash functions. Following is our revised step-by-step method of control:

Receipts by mail. Incoming mail is opened and date-stamped by the

FLOW CHART SHOWING MOVEMENT OF CASH FROM ALL DEPARTMENTS TO BUSINESS OFFICE



INTERNAL CONTROL OF CASH

The Genesee Hospital – Rochester, New York

1—CASH PAID DIRECT TO THE BUSINESS OFFICE.
2—MAILED RECEIPTS (OPENED IN DIRECTOR'S OFFICE).
3—CASH RECEIVED IN THE DIETARY DEPT.
4—CASH RECEIVED IN THE PHARMACY.
5—CASH RECEIVED IN THE OUTPATIENT DEPT.
6—CASH RECEIVED IN THE EMERGENCY DEPT.
7—CASH RECEIVED BY THE X-RAY—LAB. RECEPTIONIST.
8—CASH RECEIVED IN THE STOCK CONTROL DEPT.

LEGEND OF SYMBOLS

= OPERATION
= A MOVE
= TEMPORARY FILE
= CASH REGISTER
= CASH BOX

director's secretary, who has the responsibility of immediately recording all receipts in duplicate on a prenumbered check list. This is the initial point of control—having the secretary, rather than the business office cashier, open and record mail receipts. The original list, with the remittances, is given to the cashier. The duplicate goes to the financial secretary, who later reviews and checks all inpatient accounts.

Employes' cafeteria. A single drawer cash register with one control and eight departmental classification keys was installed. This register is used for all periods of service: breakfast, lunch, dinner, midnight and canteen. After each period of service, a register reading is taken by the dietary cashier, and all cash income for that period must prove to these figures. This "read" total is automatically recorded at the beginning and end of each period of service. (Only the chief dietitian has the control key for clearing the register during each 24 hour period.) The chief dietitian checks the receipts for each period of service and transmits the income to the business office cashier. A certified cash register receipt is given to the dietary department for all money turned in to the business office.

The business office audits the register tape, checking the beginning and ending "read" totals, and prepares a daily breakdown of income report. This is verified by the controller and then entered in a monthly control. This control total must prove at all times with the cash receipts as audited and entered by the bookkeeper.

Pharmacy. This department has a single drawer cash register with four control and nine symbol classification keys. On cash sales, no further entry need be made on the ticket. On all charges or credits the pharmacist enters the name of the patient, floor location, and prescription number.

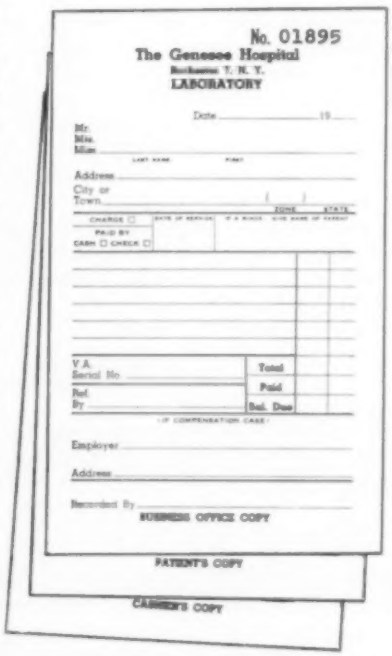
The pharmacist clears the register each day and removes the audit tape, recording on it the reset number as shown on the register. The tape total is balanced with the actual cash. These, together with the supporting clearing tickets, are turned in to the business office cashier. Charges are sent to the cashier through the pneumatic tube system several times each day.

The numerical sequence of these regular tickets is accounted for by the posting operator. All cash sale and clearing tickets and the register tape are turned over to the audit clerk for verification. Her analysis and recording must at all times agree with the audited cash recording by the bookkeeper.

Outpatient clinic. A single drawer cash register with four control and nine symbol classification keys was installed. The register receipts were designed as appointment cards for the patient's next clinic visit.

At the end of the day the OPD cashier takes a "reading" of the total, which is automatically recorded on the register tape. The tape is then removed and balanced with the actual cash. Cash and tape are then turned in to the business office cashier. The register tape and "read" tickets are given to the audit clerk for verification. She records and proves the figures with the audited cash book entry made by the bookkeeper.

The controller has the responsibility of clearing the register at the end of the month. The clearing sequence number as shown on the register is recorded on the register tape. These, together with the clearing tickets, are turned over to the audit clerk as a further means of verifying the month's entries.



Snap-out charge ticket used in x-ray and laboratory departments. All charge tickets at hospital are prenumbered.

X-ray and laboratory (private ambulatory services). A cashier-receptionist is located in a special lobby provided for patients of both services. She greets all incoming patients; prepares a snap-out charge ticket (shown above); collects for services when possible; enters payment on the cash detail slip required for audit purposes by the bookkeeper, and indicates any payments on both the patient's and business office's copy of the charge tickets. Twice each day she balances her cash with the total listings on the detail slips and turns these funds in to the business office cashier. Charge tickets are sent to the business office several times each day by the pneumatic tube system.

All charge tickets are prenumbered and accounted for by the posting machine operator. Tickets marked "paid" are then turned over to the bookkeeper, who correlates these tickets with the income and detail slips the business office cashier has received from the receptionist. Such tickets are then officially stamped "paid" and sent to file.

Emergency department. A five-part carbon snap-out form is used as the charge ticket. The form is 8½ by 11 inches and is designed to accommodate the medical information on several of the copies, and the business office detail on others.

Payments are received and recorded on cash detail slips and the total amount is recorded on the 24 hour shift summary of cash. This latter sheet is turned in weekly to the bookkeeper. Cash is forwarded to the business office cashier with the cash detail slip during normal business hours. After hours, such receipts and detail slips are turned over to the admitting officer, who checks the amounts, balances the cash, and gives a receipt for them. Receipts are then locked in the admitting office cash box and placed in a safe. This box is brought to the business office cashier the following morning. She checks all receipts, balances the change fund, signs the receipt, and returns this with the cash box and change fund to the admitting office.

Each morning after the bookkeeper completes her deposit she turns over to the transient billing clerk the certified register tickets on all the emergency accounts for the manual posting of the cash payments whether they are made in the emergency department, at the business office, or by mail.

Stock control department. Miscellaneous items are sold to employes and physicians. These are, for the most part, cash sales. Such sales are listed on a cash detail slip and when the cash on hand amounts to $10 or more, it is turned in to the business office cashier. The cash, in the interim, is kept in the cash box, locked in the stock control clerk's desk.

Receipts are given on certain items sold when they are warranted by the amount involved. In some cases, where materials or supplies are ordered specifically for an employe or physician, a miscellaneous charge ticket is created. #

Good Drug Service Calls for Cooperation Between Hospital and Retail Pharmacists

A MODERN HOSPITAL ROUND TABLE

HOW can the pharmacist in the community hospital and his colleague in the local retail drugstore cooperate most effectively to serve the needs of hospital patients and the community? How can the retail pharmacist help the hospital that doesn't operate its own pharmacy? What is the best way to work out problems of ordering and pricing drugs in the small hospital? To answer these and other questions about the relationship between retail and hospital pharmacists, the Texas Society of Hospital Pharmacists and the college of pharmacy at the University of Texas conducted a panel discussion during the University of Texas' tenth annual hospital pharmacy seminar early this year. Taking part in the discussion were William Liesch, Municipal Hospital, McAllen, Tex.; Daniel Moravec, General Hospital, Lincoln, Neb.; Lewis Smith, Baylor Hospital, Dallas; M. J. Hebert, Austin Drug Store, Alice, Tex., and George Halden, Halden Pharmacy, Austin, Tex.

Because of the importance of this subject to hospital administrators, pharmacists and communities all over the country, The MODERN HOSPITAL asked for permission to make a tape recording of the discussion. A transcript of the recording, edited to eliminate repetition and irrelevancies, follows.—ED.

Mr. Liesch: We are all in agreement that a special relationship is necessary between hospital pharmacists and retail pharmacists. We have set up affiliations, and there is much work being done to bring the organizations of pharmacy together. Are we all satisfied that we are making progress?

Mr. Moravec: Personally, I'm not—and I don't believe anyone here is. I think there's a lack of understanding of the problems in the different groups. I think pharmacy is doing much too much fighting for the good of the profession, and it goes back to an understanding of the basic problems of the different pharmacists. I think we've got a long way to go in hospital and retail relationships, and I think the only way we can do it is to get together and see that the retail group understands our hospital problems, and vice versa.

Members of the Texas round table discussion on interprofessional relations between hospital and retail pharmacists (from left to right) are: Lewis Smith, M. J. Hebert, William Liesch, Daniel Moravec, George Halden.

Mr. Halden: I agree that there are a lot of things that pharmacists in professional and private pharmacies do not understand about pharmacists in hospitals, and pharmacists in hospitals possibly don't understand a whole lot about our private work. Nevertheless, there's quite a nice relationship among us pharmacists here in Austin. I can get anything that I need from the pharmacists in any of the hospitals; I can borrow it or pay for it, or say I'm going to pay it back when I get it; and every pharmacist knows that he can do the same thing at my pharmacy. We've tried to work together. The pharmacists cooperate in every way, but they don't always run the pharmacies in the hospitals!

I, myself, or my daughter, or my wife, may be a hospital patient. I was told by the former superintendent of one hospital when my daughter was a patient that she was buying medicine at the hospital pharmacy, and if I didn't like it I could come take her out! When I brought my brother-in-law into another hospital and asked if I could furnish the medicine to him, the administrator said: "Come take your brother-in-law out of here. If he wants medication he'll buy it at this pharmacy, and if you don't like it, take him out!" Administrators tell the doctors, "If you want to insist on medicine coming from a private pharmacy, you cannot practice in this hospital."

This has nothing to do with the pharmacists. They're working for the hospital; as long as a man draws his pay check from a certain source, he should cooperate with its policies. If he feels that he cannot cooperate, he should get out.

Another thing that I've been told

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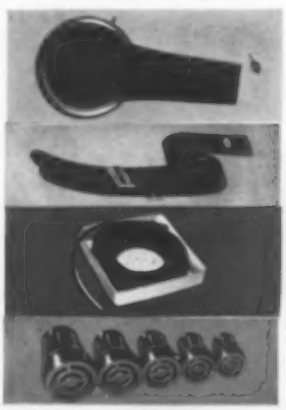

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about the pharmacies in hospitals is that they get together and decide on whose preparations they're going to use. When the doctor writes a prescription, if he specifies the manufacturer, we private pharmacists consider that we would be violating our trust as pharmacists if we didn't give him the product that he wrote for.

Voice: The good hospital pharmacist does not, even with a formulary, substitute another company's products, if the name is written on the prescription.

The practice is a little different in a hospital from what it is in a retail pharmacy, however. In the hospital the doctors have gotten together previously and have directed the pharmacy service, or the pharmacy department, to give the brand that they can buy the cheapest, as long as it is from a reliable company. The pharmacist there is not actually substituting but simply carrying out the wishes of the doctor concerned. Of course, if we give the patient something that we know nothing about, then we are breaking our trust, and we have no business doing that. But in most hospitals if something is written, it is with the understanding that the pharmacist supply a reliable brand that is in stock. I don't believe it's an issue of the hospital telling the doctor what he's going to do.

Mr. Halden: We have often talked about the designation "Any Reliable Brand." My definition is: Any house that does extensive research; that's "any reliable brand."

But any time you open up a prescription and find "ARB" there, you may run into danger, because you are likely to buy where you can get the cheaper grade. Your definition of "any reliable brand" may be different from my definition.

Mr. Moravec: "ARB" is a dangerous thing. I don't think anybody should use that term. Without a formulary that sets the specifications of the product, it is wrong. But as long as you have a formulary that sets specifications, below which the pharmacist is not allowed to go, that is the important thing. By itself, "ARB" is dangerous.

Mr. Smith: In making a formulary in the hospital, we have the doctors agree as to what they are going to use; they have given us written permission to use what we have in stock.

My policy for a long time has been to buy the first brand *that was a reliable brand* that came on the market. The first one that comes out has done the original research, and I think they deserve the play on a drug. If a doctor sent me a prescription and specified that he wanted "A brand," and no other brand, I'd just send it back and tell him that I don't have it, that I have only what is listed in the formulary—and I forget the problem. If he wants to go elsewhere, that's his business. I don't see that there's any need to get all worked up about the idea of having a formulary where you list what you're going to supply and have the doctors agree on it. Let them work it out among themselves and you'll get along all right!

Mr. Hebert: I should think using the retail pharmacy would be more desirable for the doctor. If he wants to write a certain brand, he picks up the direct line to the drugstore and orders it, and I send it over there!

I went before the board of directors of the hospital three years ago and made them a proposition that I would furnish their drugs at cost plus 10 per cent, which in a lot of cases is cheaper than they could buy. Then I offered to process and collect any inpatient prescriptions that I might fill for 10 per cent. That's been working out very nicely. The hospital buys about $3000 to $4500 worth of drugs a month. They carry only about $200 worth of stock on inventory, instead of $50,000, and the doctors get what they write for! (*Cont. on Page* 92)

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It's all up to the administrator. If the hospital has a good administrator, the system works. Our administrator knows drugs, and he knows the cost of drugs. I tell him the mark-offs to him for capsules, or per ounce, or per tablespoon, or whatever he wants, and he makes a list, so that the nurse who dispenses the drugs charges the right price.

Mr. Liesch: It's evident that we're not fully satisfied with the relationship. Will anybody offer any further suggestions for improving this relationship?

Voice: One speaker objected to the fact that he couldn't bring drugs into the hospital for his own family. The problem is that the hospital is legally responsible for everything that goes on there; the nurse is legally responsible for every drug she administers. The hospital pharmacist is responsible for the drugs in the hospital, no matter where they are—in the pharmacy, or a nursing unit, or wherever they may be—the pharmacist is responsible. It's only proper, then, that all drugs should come through his department, else how can he fulfill his responsibility? That is the reason you cannot supply the drugs for the members of your own family.

However, many hospitals have a policy of offering discounts to professional people, and so you would get back part of your expenses for the drugs for your own family.

Mr. Moravec: Whenever a pharmacist or a member of his family comes into our hospital, 50 per cent of his drug needs can be made up by him, and I think that's a possible way to improve the relationship. I don't like to see a pharmacist come in and pay 50 cents or 75 cents for something he knows he can buy for 32⅓ cents or 25⅝ cents. So in order to show the pharmacist that we are working together I have seen the company representatives come in and replace up to 50 per cent of the amount used, free of charge. Then we're happy to be able to run through a credit to bring the bill to the pharmacist down. I offer that to you as a possibility.

Voice: If the administrator considered every group in the hospital asking for discounts he wouldn't be running in the black very long. If he starts that, pretty soon he won't be a hospital administrator.

Mr. Moravec: I think we should give our fellow pharmacists discounts on drugs, but I don't think department heads should have that prerogative; I think it should be in the administration. But I believe, a good pharmacist, a person in whom the administrator has a lot of confidence, can present the situation to the administrator, and say: "Look here, this man pays 32 cents for this drug. He's paying 75 cents here, and he knows it; besides, he's a fellow pharmacist. I'm going to do everything I possibly can, with your permission, to help this man out."

Voice: I appreciate my administrator more after hearing this discussion here today. We have 25 or 30 pharmacists in our town. When one of them comes to our hospital, the administrator usually comes to me and asks me if he is a pharmacist in good standing. If he is, he gets a straight 25 per cent off his total hospital bill.

Voice: The thing that interests me is trying to justify the prices charged for medicine to make up deficits in other departments. I wonder if you really are playing fair with yourselves as pharmacists, or with the profession of pharmacy, by permitting the high charges of some hospitals to be entered and credited to pharmacy?

It doesn't do pharmacy any good in the eyes of the public to permit exorbitant prices on medicines ordered out of the hospital pharmacy. What deficits are the hospitals making up? Is it the x-ray department? Is it the cast room? Whatever it may be, why not let each department bear its own expenses? Let the pharmacy stand on its own feet and operate at minimum

expense. You'd be doing pharmacy a great service if you did not make it the scapegoat for the high prices charged patients in other departments.

Voice: We want to get these charges separated, but it's not something you can do overnight. There is going to be a transition period of many years. The departments, as you say, should carry their own expenses. I think we all agree. But what are you going to do about the laundry? Housekeeping? Engineering? Any number of non-paying departments?

That money has to come from somewhere. A hospital that has a million dollar budget is going to have to take in a million dollars. That's something that we're going to have to work out as hospital pharmacists, with the administrators. We're going to have to get this business separated, but we're not going to be able to do it in the next 10 days!

Mr. Hebert: I'm sure that the state boards of pharmacy and all the enforcement agencies would be gratified if it could be resolved. There is a national concern about the need for improved pharmacy service in our smaller hospitals. A recent article in the *Professional Pharmacist* said: "Leaders in pharmacy have long been aware of the need for introducing professional pharmacy into the large number of the nation's smaller hospitals which now lack such service. Attention has been focused on the significant contribution which pharmacists can make to the solution of this problem."

If the hospitals will work with the pharmacists in their communities and depend on them for all the preparations that have to be weighed and measured, and also buy their drugs from the pharmacist at a nominal markup, we can improve service in these hospitals. If they buy $3000 worth of merchandise, it may cost them $300. They couldn't hire a pharmacist for that! It really doesn't cost them that much if there's cooperation in collection of the inpatient prescriptions, and also the extra discounts that the pharmacist passes on to the hospitals.

Mr. Smith: A hospital that has 60 beds or more can use a pharmacist, and use him well. A good deal of education is needed for administrators. They don't realize that they are going to have to pay pharmacists to make them take hospital jobs! Also, they have to find out that pharmacists can do other things besides pharmacy if it's necessary. But if they have 60 beds, it can be a good job if it's handled correctly.

But even so the hospital certainly should work up a better relationship with the local pharmacist, so that he can handle situations after the hospital pharmacy is closed, because such situations are going to come up if they operate a good hospital. One of the biggest jobs is an educational program for administrators. In the administration schools at some of the universities, the students learn that they can economically use a pharmacist at about 60 beds. But administrators who haven't had this formal training are pretty hard fellows to sell on this!

Voice: Why should the people who are in a hospital with less than 60 beds be subjected to someone filling their prescriptions who's not a pharmacist? Whether the hospital has five beds or 10 beds, if the patient gets a prescription filled he should have it filled by a pharmacist, and not by some nurse!

Mr. Smith: A 60 bed hospital would have enough business normally to need a pharmacist. At that size it could certainly have one. Smaller hospitals could have one provided they figured out other work in the hospital that the pharmacist could take care of. But I didn't mean in any event that a prescription could be filled by anybody besides a registered pharmacist, regardless of what size hospital it is. #

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A Successful Formulary System Must Be Based on Sound Professional Principles

Don E. Francke

METHODS of operation of the formulary system differ somewhat from hospital to hospital. While this is inevitable, and in some respects desirable, there are still certain principles upon which the operation of the formulary system in all hospitals should be based. Some of these guiding principles may be stated as follows:

1. View the formulary as a dynamic, ever changing compilation of modern pharmaceuticals selected with discrimination, not as a static, fixed, inflexible list of drugs and preparations.

2. Maintain a formulary which reflects the clinical judgment of the hospital's medical staff and is a critical selection of those drugs that are considered most useful therapeutically, together with the preparations whereby these drugs may be administered most effectively.

3. Supply to each member of the medical staff clearly written policies and procedures governing the operation of the formulary system which have been formulated by the pharmacy and therapeutics committee and approved by the medical staff and administrator.

4. Dispense the brand of drug prescribed on each individual prescription or contact the physician and obtain his permission each time before another brand of the drug is dispensed, if no written, approved policies relative to the operation of the formulary system exist.

5. Agree to an *administrative* policy to dispense another brand of a drug in place of the drug prescribed *only* when that policy has been approved by the medical staff.

6. Formulate procedures for obtaining nonformulary drugs which are simple, fair and reasonable, and do not involve needless delays and complicated red tape.

7. Strive for a formulary system which will provide, in addition to drugs accepted into the formulary, for:

a. The clinical evaluation of nonformulary drugs by members of the medical staff;

b. The clinical evaluation of investigational drugs;

c. The exercise of a physician's professional prerogative in instances when he believes a specific brand of a drug is important to the care of his patient.

8. Remember that the pharmacist is responsible for ". . . specifications, both as to quality and source, for the purchase of all drugs, chemicals, biologicals and pharmaceutical preparations used in the treatment of patients . . ." according to the Minimum Standard for Pharmacies in Hospitals. This responsibility is inherent in the proper operation of a good formulary system.

9. Keep the pharmacy and therapeutics committee effective by a well prepared, challenging and interesting agenda, by compiling and distributing background information on items to be discussed, by holding regular meetings, and by communicating the committee's recommendations to the medical staff.

10. Utilize the pharmacy and therapeutics committee, of which the pharmacist is an active, voting member, to establish and maintain good communications and liaison between the pharmacy and the medical staff in the interest of better patient care. Remember that the hospital pharmacist is a member of the health team that serves the patient.

A well operated formulary system must be guided by principles which are just and fair to the patient, the medical staff, the pharmacy staff, and the hospital. Especially important is the spirit with which the system is operated. If the pharmacist, on whom falls the responsibility of implementing the formulary system, maintains an attitude of helpful cooperation with the medical staff; if he fosters the formulary system as an educational tool for practitioners and students of medicine, nursing and pharmacy; if he encourages the acceptance and use of really new and better drugs as they are developed and evaluated, and if he employs the formulary system to actively promote better patient care—if he does these things and is guided by sound professional principles, the formulary system in his hospital will be well accepted by all. #

Reprinted by permission from *The Bulletin* of the American Society of Hospital Pharmacists, November-December 1957. Dr. Francke is chief pharmacist at University Hospital, Ann Arbor, Mich., and editor of *The Bulletin*.


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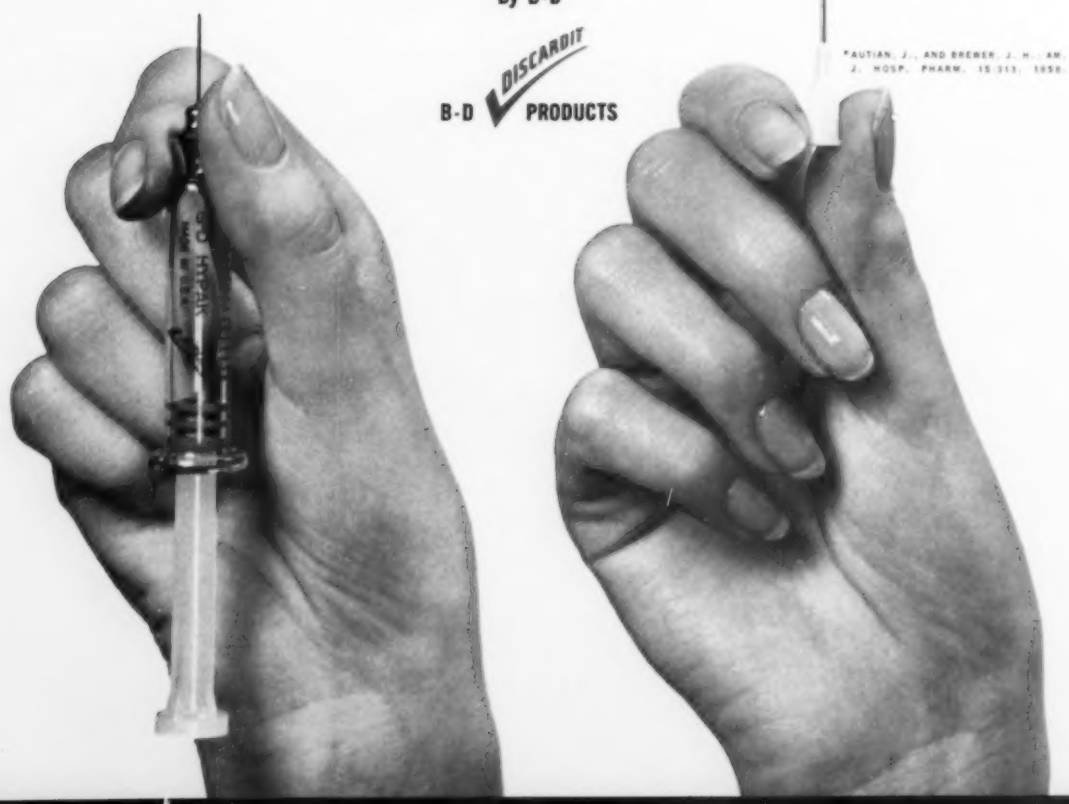

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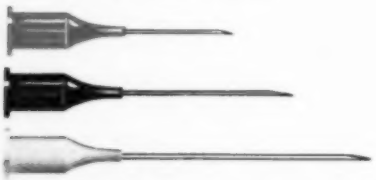

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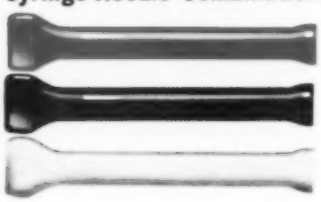

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Conducted by Mary P. Huddleson

How to Make the Most of Fabricated Foods

A revolution in the food preparation and processing industry is just around the corner, but it will arrive sooner if food processors, manufacturers and consumers work together to develop the most satisfactory products

Lendal H. Kotschevar

WITHIN the next several decades institutional food preparation will undergo a major revolution. Convenience foods, automation and other improved equipment will be major factors in bringing this about.

The speed with which this revolution occurs will depend largely upon how well industry and food services work together. In some instances industry has already outstripped current demands of food services and is producing items which food services could use to great advantage; however, because of reluctance to try new ideas food services have sometimes been unwilling to accept these improved products or equipment. This is not unusual, and manufacturers should realize that there is always a reluctance to give up a tried and proved method for a new product and there will always be inertia to overcome.

In other instances industry has produced equipment and foods which have not been successful either because industry has misinterpreted the need for such items or because the product has lacked quality as one of its factors. Misinterpreting the market in this manner is costly to a manufacturer and leads frequently to his reluctance to try new things again. Greater care in determining both the need for the product and the quality required would eliminate some of the hazard.

There is an increasing need today for food services and industry to work together toward the common goal of bringing the full advantages inherent in automation and convenience foods more rapidly into the food service industry.

This need for cooperative effort is well illustrated in the hesitant acceptance in many markets of fabricated meat (prepared in individual cuts—well controlled portions—prior to marketing).

About 10 years ago fabricated meats made their appearance and acceptance in certain areas was fairly rapid up to a point. The idea was a good one, aiding as it did management control of portions and costs in the institution. Labor savings could be made through utilization of mass production methods, and the lessened need for supervision of skilled butchers was a relief to management. However, the meat processors producing fabricated meats made several mistakes. They failed to study the market closely.

In the first place, they did not realize the need for well written specifications in order to assure standard high quality products in purchase. This allowed inefficient meat processors to enter the market and sell fabricated meats of low quality. The market would have been much more efficiently and rapidly developed had manufacturers realized the need to work closely with institutions and assist them in developing adequate specifications to guarantee quality and the meat cut desired.

Another error on the part of both food services and processors of fabricated meats was the failure to make investigations which actually proved the savings that could be made. Only recently has it been known that the cost of cutting out meat products from wholesale cuts or carcass is approximately 8 cents per pound in the institution. Furthermore, the extent of trim and bone wastes in processing meats was not well known. Cooperative efforts on the part of food operators and industry in making these tests prior to introduction of product would have opened the way for a wider acceptance of these meats; manufacturers and operators would thus have been better able to determine how maximum savings could be made.

If information such as the following had been available to purchasers, much of the reluctance to use a new product would have been overcome:

"Fresh liver was skinned, deveined, the gristle removed, and then cut into 4 ounce portion slices by a skilled meat cutter in a restaurant. The waste was between 10 and 15 per cent on each liver prepared. The variation in size and shape of the liver slices was noticeable, with weight variations over or under the average of 4 ounces being frequently greater than half an

Lendal H. Kotschevar is chairman of the department of home economics and director of food services at Montana State University, Missoula. Dr. Kotschevar received a bachelor of arts, bachelor of science, and master's degree from the University of Washington and a doctorate from Columbia University. He is a former technical director of navy commissary research. Currently, he serves as chairman of the administrative internship committee and chairman of the career guidance committee of the American Dietetic Association.

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Sirloin top butt steaks	33	Full bone-in strip
Boneless rib steaks	29	Standing rib
Boneless sirloin top butt steaks	30	Full boneless butt
T-bone steaks	41	Pinbone sirloin
Pork loin cutlets	10	Full loin
Pork tenderloin steaks	76	Whole pork tenderloin
Center cut pork chops, bone in	38	Light, lean 12/16 lb. loins
Semi-center cut pork chops, bone in	68	Light, lean 8/10 lb. loins
Center cut ham steaks, bone in	26	Whole hams
Center cut ham steaks, boneless	76	Boned hams
Ham steaks, end cut	33	Ham butt and shank ends
Fresh ham	76	Bone-in hams
Pork loin	57	Whole bone-in loin
Beef chuck eye	14	Bone-in chuck
Beef shoulder clod	18	Bone-in chuck
Beef top round	28	Straight round
Lamb leg, bone in	71	Straight leg
Lamb leg, boneless	65	Straight leg
Lamb shoulder, boneless	67	Bone-in shoulder
Veal leg, bone in	75	Bone-in leg
Veal leg, boneless	68	Straight leg
Veal shoulder, boneless	60	Bone-in shoulder
Broilers, 12 to 24 oz.	67	N. Y. dressed
Fryers, 1½ to 2½ lbs.	67	N. Y. dressed
Fowl, 2 to 3¼ lbs.	67	N. Y. dressed
Ducks, 3½ to 5 lbs.	70	N. Y. dressed
Turkeys, 9 to 18 lbs.	75	N. Y. dressed
Geese, approximately 10 lbs.	70	N. Y. dressed
Cod fillets	33	Whole cod
Flounder fillets	25	Whole flounder
Haddock fillets	33	Whole haddock
Halibut fillets and steaks, trimmed	43	Whole halibut
Lobster meat	38	Whole eastern lobsters
Red perch fillets	20	Whole red perch
Swordfish steaks	80	Whole swordfish

ounce. Eighteen minutes were required to process an 8½ pound liver or approximately 2½ minutes per pound. At a cost of $2.50 per hour for the skilled meat cutter, the cost per pound was increased 10½ cents. Trim loss ran an average of 12 per cent or 3½ cents per pound. The original price of the liver was 31 cents per pound. The final pan-ready cost was 45 cents per pound. Fabricated liver could be purchased for 40 cents per pound with weight variations for each individual portion over 4 ounces not being greater than one-quarter ounce."

Food service operators themselves should have made more such investigations or cutting tests in their own operations to gain this information. If they lack such information and note that the price per pound of the fabricated item is considerably higher than that of the wholesale cut or carcass price paid, they quite naturally refuse to purchase the fabricated item. Information contained in the accompanying table has only recently become available to institutions. Much more information of this nature is desirable if operators are to be able to calculate the savings possible by purchase of fabricated meats.

Another factor which led to reluctance in accepting fabricated meats was that many processors were freezing their products and then shipping them. The advantage was obvious. Freezing meant that large meat packers located near primary cattle markets could not only process the carcass or wholesale cut but could fabricate it as well and then freeze it. Mass production methods were possible because of the large volume involved. However, too frequently improper or slow freezing methods were used to freeze the meats and the resultant coarse crystalline structure of the meat destroyed texture and flavor.

Little knowledge was available, too, on the proper way to cook frozen meats. For the most part meats were allowed to thaw and then were cooked. Large losses from drip in thawing occurred with a resultant loss of flavor and moisture. Therefore, operators were reluctant to use such products.

Research done by me and others indicated, however, that flavor differences and improved moistness would result when the cooking process began while the meat was still frozen. Meat companies, however, were slow to get this information out to clients using frozen fabricated meat. The fact is that even today reliable organizations representing the meat industry state in their instructions for cooking frozen meat that there is no appreciable difference in the taste of meat cooked with or without preliminary thawing. This results in poor products which hurt sales. More and more sound information is now reaching consumers, however, and, at present, virtually every major packing house producing frozen fabricated meat advises that cooking begin at the frozen state.

Cooking methods and degrees of doneness for frozen meats vary little from those for the unfrozen or "fresh." The greatest difference is in cooking time interval. However, some changes in method can reduce cooking time. Hard-frozen roasts require approximately one-third io a half extension of total cooking time beyond that required per pound for fresh roasts. I have suggested that cooking time can be shortened if frozen meats are allowed to thaw until they reach the crystalline stage in defrosting and then are cooked. This will considerably shorten cooking time without a heavy drip loss occurring. It should be stressed that severe drip losses occur when meats thaw *beyond* the crystalline stage and are completely defrosted prior to cooking.

Research by one major meat packer has indicated that thin hard-frozen steaks could be treated much like fresh steaks in broiling. Thicker steaks, however, were found to be better flavored and juicier if the broiling rack was lowered until thawing was almost complete and the rack then raised to a normal level to complete broiling. The same company advised the complete thawing, before broiling, of steaks thicker than 2 inches. I have found, however, that if steaks 2 inches thick or more are thawed by being immersed in hot fat until only a small core of frozen material remains in the center and then are treated as a fresh product for the remaining part of the cooking period, a successful, highly flavored product is obtained. Formation of a hard crust is avoided and broiling losses are much the same as for fresh steaks. This method of cookery can also be used for even thinner products in order to reduce cooking time.

Certainly the use of fabricated meats would have been expedited had industry and food services cooperated in the development of the market,

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T. E. Albers, M.D.
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and the interests of both would have been furthered. Today precooked frozen foods and many other new products are finding slow acceptance because manufacturers and users did not get together in the original product development.

Food operators certainly should not leave to manufacturers alone the responsibility for testing and proving a product. Greater cooperation would benefit both by the development of better products. Manufacturers, however, should realize that the testing and use of a product may be difficult to do in an operation whose main purpose is to operate at a profit. Cooperation in defraying costs of such testing will encourage more and more operators to test products for the market. #

Dish Machines Can Wash More Than Dishes

Many of the bulky, unwieldy pieces of equipment used in food service operation, such as hood filters, sheet pans, and cafeteria pans, can be cleaned in the dish machine at considerable saving of man-hours if there is adequate supervision and regulation of the operation to prevent breakdown of racks and machine

R. A. Smith

BY USING the three main types of dish "racks" on the market today for standard American equipment, items other than dishes, silver and glasses can be cleaned in a conveyor type of dish machine.

With the proper racks for the machine, and if care is taken in selecting the equipment to be cleaned and placing it in the racks, many man-hours can be saved in the cleaning operation of a food unit.

However, regulations and supervision are essential to prevent needless breakdown and repair of both racks and machine. First, the correct type of rack for a particular machine must be chosen. Otherwise, undue wear on both machine and rack will result. For example, if a manual rack is inserted in an automatic machine, the chain dogs will damage the rack structure, because the automatic machine has index strips for the dogs to push on instead of on the rack frame.

The three main types of racks usually measure 20 inches by 20 inches. One is the plate rack, which usually has two cross rails that serve to hold plates and saucers upright during the washing process. Second is a rack that is divided to hold 16 cups inverted through the operation. Third, and most important to this discussion, is the "silver rack."

This is an open box, except for the bottom. It has crossed wires that hold equipment but allow water to pass freely over from the top and bottom spray arms of the machine. Some have dowels and wire mesh; others are made entirely of wire.

The following pointers should be considered in using the dish machine for other items of equipment:

1. **Washing and sterilizing hood filters.**[1] These filters usually are more than one in a series. They are held on rails above fry tops to filter out grease before the air is drawn into the exhaust system. The best way to clean filters is with a steam hose that forces steam through the filter and removes the grease. However, for daily cleaning, the filters may be put in a silver rack and sent through the dish machine. One end of the filter lies on the bottom of the rack, the other end rests on the top of the opposite side of the box. Since the filters also are 20 inches long, it is extremely important that they ride inside the rack. If not, they can easily jam the chain or interfere with the rack's passage through the machine. This might either break the dogs on the chain that carry the rack through the machine or jam the equipment in such a way as to stop the machine entirely.

2. **Washing grease splashed trays.** These trays are usually placed behind a portable grill to catch splashing grease and prevent it from collecting and running over the top of the fry table to the floor. These trays can also be put through the dish machine if they are handled carefully but, because of their design, it is not advisable to put them through a dish

R. A. Smith, who discusses additional uses for a dish machine operation, has been the food director at the Erb Memorial Student Union of the University of Oregon for the last four years. He received a degree in institution management from the University of Washington, where he also served a year's dietetic internship. Mr. Smith spent three years in the navy commissary department, and attended the navy's commissary school. He is a member of the National Restaurant Association and the American Dietetic Association.

[1] As used here, the term "sterilization" indicates the commonly known result from a rinse spray temperature of 180°F. plus. It is understood that, in scientific terms, this is not complete sterilization.

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machine. They are made to collect a liquid and thus have a rather deep receptacle to hold the liquid. When put through the machine, if they are inverted, too often the wash spray force is not sufficient to get the grease out of all the corners. If they are sent through the machine in an upright position, naturally, the receptacle merely serves as a storage for the rinse and wash water and thus the job of washing is not complete. Therefore, it is recommended that these trays be washed daily in the pot and pan sink along with other pieces of equipment which, because of their structure, weight or bulkiness, are just not suited to go through a dish machine.

3. **Washing and sterilizing bussing pans.** These pans, or trays, are 21 inches long, 16 inches wide, and 5½ inches deep. They must be cleaned daily, in addition to being rinsed after they are emptied from each trip to the dishroom. It is possible to put these trays through the dish machine by inverting them in a silver rack. One end should ride in the bottom of the silver rack and the other end must rest on the top of the far side of the rack. Thus, the tray can go through the machine riding on top of the silver rack without interfering with the forward motion of the chain or the dogs, or stopping the machine in any way. Again, care must be taken in placing the tray in the silver rack.

4. **Washing and sterilizing salvaging strainers and pots.** Although it is possible to send these items through the machine with care and constant supervision, it is not a wise procedure. Because of the size of this type of strainer, any improper placing in the rack or jarring during the trip will result in stopping the machine. Possible results are breaking links in the chain, bending wash arms, or bending the trolley that the train rides on. Therefore, the strainer must be either steamed or washed by hand, even though hand labor is involved.

5. **Washing and sterilizing cafeteria trays.** These trays will make the trip with no difficulty if placed in plate racks as plates are. At the discharge end, they should be tipped to the opposite side of the rails to allow steam drying. However, if they are properly placed at the beginning of the operation, this tipping should not be necessary.

6. **Washing and sterilizing sheet pans.** These pans are 25¾ inches long, 17 inches wide, and 1 inch in depth. Because the racks are 20 by 20,[2] the sheet pans must be handled like the hood filters, grease trays and bussing pans. If they are allowed to pass through by merely riding on top of the rack, they can cause serious damage by stopping proper operation of all moving parts.

7. In addition to the foregoing odd shaped pieces, there are any number of small pieces of equipment that will fit nicely inside the 20 by 20 inch box and can be cleaned and sterilized by a trip through the dish machine. Some of these are: coffee leeches; coffee pots; small food containers; pots, pans and pails that are not of large size, bulk or weight; milk shake tins, and salad bowls and salad equipment.

It is possible, therefore, to wash many pieces of equipment in a dish machine, other than plates, cups, silver and glasses. However, regulations and supervision are essential to prevent needless breakdown and repair of both racks and machine. With proper regulation and supervision there can be valuable savings of man-hours of labor in the cleaning operation of a foot unit. #

[2]There are other different shapes and sizes for racks that are made to pass through a dish machine. For example, there is an item on the market called a "half rack" which is merely one-half as wide as the 20 by 20 inch rack. Keep in mind that the 20 by 20 inch rack will ride through the machine in either direction. However, if it is an automatic machine, the automatic rack will have index strips on it so that the rack must ride through with the index strips parallel to the trolley.

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Heinz 57

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Menus for August 1958

Alma K. Howell
Head Dietitian
Louise Obici Memorial Hospital
Suffolk, Va.

1
Grapes
Scrambled Eggs
•
Fried Trout
Buttered Potatoes
Green Peas
Under the Sea Salad
Hot Rolls
Peach Shortcake
•
Cold Plate:
Tuna Salad
Potato Chips
Pickles
Chocolate Pudding

2
Grapefruit Half
Cheese and Eggs
•
Chicken Pie
Baked Sweet Potato
Kale
Celery and Pickle Salad
Strawberry Gelatin
•
Liverwurst, Salami
Sliced Cheese
Potato Salad
Sliced Kosher Dill Pickles
Yellow Cake With
Chocolate Frosting

3
Bananas
Hard Cooked Eggs
•
Baked Ham
Escalloped Potatoes
Asparagus
Mixed Green Salad
Coconut Pie
•
Beef and Macaroni
Casserole
Brussels Sprouts
Pickled Beets
Fruit Cup

4
Fresh Pears
Scrambled Eggs, Bacon
•
Broiled Liver,
Onion Gravy
Rice
Buttered Spinach
Waldorf Salad
Ice Cream
•
Vegetable Soup
Ham Croquettes
Noodles
String Beans
Spiced Peach Salad
Cherry Cobbler

5
Baked Fresh Apple
Grilled Bacon
•
Fried Chicken
Corn Pudding
Buttered Spinach
Hot Rolls
Jellied Cranberry Salad
Ice Cream
•
Cold Plate:
Baked Ham
Potato Salad
Pickles and Olives
Vanilla Pudding With
Sliced Peaches

6
Sliced Orange
Scrambled Eggs
•
Roast Turkey,
Dressing and Gravy
Orange-Glazed Sweet
Potatoes
Green Peas
Peach With Cottage
Cheese Salad
Pumpkin Pie
•
Meat Loaf,
Tomato Sauce
Mashed Potatoes
String Beans
Congealed Fruit Salad
Cookies

7
Grape Juice
French Toast, Sausage
•
Barbecued Beef, Buns
French Fried Potatoes
Butter Beans
Fruit Salad
Ice Cream
•
Smoked Tongue
Buttered Hominy
Fresh Kale
Hot Biscuits
Apple Pie

8
Grapefruit Half
Scrambled Eggs
•
Fried Trout
Mashed Rutabagas
Oven Browned Potatoes
Coleslaw
Cornbread
Pineapple Chiffon Pie
•
Salmon Casserole
With Biscuit Topping
Whole Kernel Corn
Peas and Carrots
Cottage Cheese Salad
Gingerbread

9
Pear Nectar
Soft Cooked Eggs
•
Hamburger Steak
Oven Browned Potatoes
Stewed Tomatoes
Grated Carrot and
Pineapple Salad
Fruited Gelatin
•
Roast Lamb,
Mint Jelly
Rice
Buttered Green Peas
Pear Salad With
Grated Cheese
Lemon Meringue Pie

10
Grapes
Scrambled Eggs, Bacon
•
Smithfield Ham
Corn and Butter Beans
Spinach
Spiced Peach Salad
Hot Rolls
Caramel Peach Float
•
Hungarian Goulash
Buttered Broccoli
Lettuce and Tomato
Wedges
Blueberry Pie

11
Tangerine
Bran Muffins, Sausage
•
Pot Roast With
Vegetables
Cabbage
Cornbread
Spiced Cucumbers
Ice Cream
•
Chicken Curry
Baked Sweet Potato
Kale
Grapefruit Section Salad
Baked Custard

12
Orange Juice
Hot Cinnamon Buns
•
Southern Fried Chicken
Mexican Corn
Seasoned String Beans
Grapefruit and Pineapple
In Orange Gelatin Salad
Ice Cream
•
Grilled Luncheon Meat
Baked Beans
Mixed Vegetables
Sliced Tomato Salad
Bread Pudding
With Raisins

13
Bananas
Pancakes, Sirup
•
Breaded Veal Cutlet,
Tomato Sauce
Baked Potato
Buttered Carrots
Apple Salad
Baked Custard
•
Braised Pork Chop
Mashed Sweet Potatoes
With Marshmallows
Fresh Collards
Pickle Relish
Deep Dish Apple Pie

14
Tomato Juice
Scrambled Eggs
•
Spaghetti With
Meat Sauce
French Bread
Tossed Green Salad
Lime Sherbet
•
Braised Cube Steak
Black Eyed Peas
Escalloped Tomatoes
Molded Cranberry and
Orange Salad
Banana Shortcake

15
Hot Spiced Applesauce
Soft Cooked Eggs
•
Baked Rock Fish
Parsleyed Potatoes
Buttered Carrots, Peas
Corn Sticks
Coleslaw
Lemon Gelatin With
Whipped Topping
•
Salmon Cakes
Mashed Potatoes
Broccoli
Head Lettuce Salad,
1000 Island Dressing
Coconut Cake

16
Stewed Prunes
Scrambled Eggs, Bacon
•
Roast Beef
Buttered Potatoes
Asparagus
Cabbage-Carrot Salad
Cornbread Squares
Cookies, Ice Cream
•
Ham-Stuffed Peppers
Whole Kernel Corn
String Beans
Tomato, Cottage Cheese
Salad
Pineapple Pie

17
Orange Sections
Waffles, Sirup
•
Roast Pork
Paprika Potatoes
Squash and Onions
Mixed Vegetable Salad
White Cake With
Jam Topping
•
Chicken Chow Mein
Chinese Noodles
Buttered Rice
Buttered Peas
Waldorf Salad
Sliced Peaches

18
Peach Nectar
Baked Eggs
•
Smothered Steak
Hashed Brown Potatoes
Spinach, Lemon Sauce
Celery and Pickle Sticks
Gingerbread-Apple
Upsidedown Cake
•
Chili con Carne
With Kidney Beans
Asparagus, Cheese Sauce
Pepper Slaw
Garlic French Bread
Orange Cake

19
Apricot Slices
Scrambled Eggs
•
Baked Chicken
Succotash
Harvard Beets
Perfection Salad
Pineapple Sherbet
•
Chinese Omelet
Field Peas
Broiled Tomato
Spiced Pear Salad
Peanut Brittle Bread
Pudding

20
Stewed Apples
Sausage Patties
•
Broiled Lamb Chops
Candied Yams
Creamed Peas
Head Lettuce,
French Dressing
Fruit Cup
•
Roast Veal
Corn on the Cob
Buttered Lima Beans
Tomato Salad
Lemon Pudding

21
Orange, Grapefruit Juice
French Toast, Bacon
•
Hamburger Patties
Spanish Rice
Buttered Spinach
Molded Cucumber Salad
Peach Cobbler
•
Chicken Fricassee
Buttered Cauliflower
Pear Salad
Devil's Food Cake

22
Baked Spiced Pears
Pancakes, Sirup
•
Baked Haddock
Baked Stuffed Potato
Seasoned Kale
Carrot, Celery Strips
Cornbread
Cherry Pie
•
Cold Plate:
Tuna Salad
Potato Sticks
Cranberry Jelly With
Orange Slice
Peach Tapioca

23
Tangerine Juice
Grilled Ham, Muffins
•
Country Style Steak
Buttered Noodles
Brussels Sprouts
Peach Salad With
Cream Cheese
Pocketbook Rolls
Caramel Custard
•
Macaroni and Cheese
With Sausage Cakes
Broccoli With Cream
Sauce
Sliced Tomato Salad
Fruit Cocktail and
Gelatin Cubes

24
Prune Juice
Scrambled Eggs
•
Barbecued Chicken Legs
French Fried Potatoes
Asparagus in Pimiento
Ring
Molded Apricot,
Nut Salad
Sliced Pineapple
•
Cheese Fondue
Buttered Vegetables
Congealed Grapefruit,
Cucumber Salad
White Cake With
Butterscotch Sauce
and Pecans

25
Bartlett Pears
Cheese and Eggs
•
Rib Roast of Beef
Parsleyed Rice
Buttered Squash
Molded Apple Salad
Ice Cream
•
Chuckwagon Steak
Noodles
Stewed Tomatoes
Tossed Green Salad
Butterscotch Pie

26
Honeydew Melon Wedge
Creamed Ham Omelet
•
Corned Brisket
Cabbage
Buttered Potatoes
Pickled Beets
Corn Muffins
Jelly Roll
•
Club Sandwiches:
Sliced Turkey, Bacon,
Lettuce, Tomato
Potato Chips
Home-style Pickles
Banana Pudding With
Meringue Topping

27
Cranberry Juice
Scrambled Eggs, Sausage
•
Broiled Steak
Julienne Potatoes
Buttered Broccoli
Lettuce Wedge With
Garlic Dressing
Hot Buttered Rolls
French Apple Pie
•
Cold Plate:
Chicken Salad on
Lettuce, Sliced Tomato
Party Pickles
Cheese Breadsticks
Brownies With Nuts

28
Pineapple Juice
Raisin Muffins
•
Crab Cakes, Scallops
Buttered Potatoes
Wax Beans, Cheese Sauce
Tomato, Cucumber Slices
French Rolls
Peach Shortcake
•
Oven Browned Shortribs
au Gratin Potatoes
Hanover Greens
Deviled Egg Salad
Orange Sherbet

29
Bananas
Waffles, Sirup
•
Shrimp Creole
Buttered Rice
Tiny Green Peas
Waldorf Salad
Chinese Chews
•
Breaded Oysters and
Shrimp
French Fried Potatoes
String Beans
Tomato Aspic
Spoonbread
Lemon Sponge Pudding

30
Sliced Peaches
Soft Cooked Eggs
•
Liver Chips,
Onions and Gravy
Rice
Parmesan String Beans
Spiced Apple Rings
Chocolate Cobbler
•
Salmon Loaf
Creamed Potatoes
Tiny Whole Carrots
Pineapple Spears
and Pepper Ring Salad
Lemon Bisque

31 Baked Apples, French Toast • Baked Ham, Escalloped Potatoes, Stewed Tomatoes, Hot Rolls, Fruit Salad, Ice Cream • Beef and Macaroni Casserole, String Beans, Cornbread, Spiced Cucumbers, Gingerbread

Ready-to-eat or cooked cereals served on all breakfast menus.

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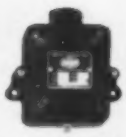

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AC UNI-PACT HORNS
Cat. No. 121-U Megaphone Projector

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AC "CM" VIBRATING BELLS
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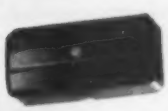
Cat. No. 110-AC



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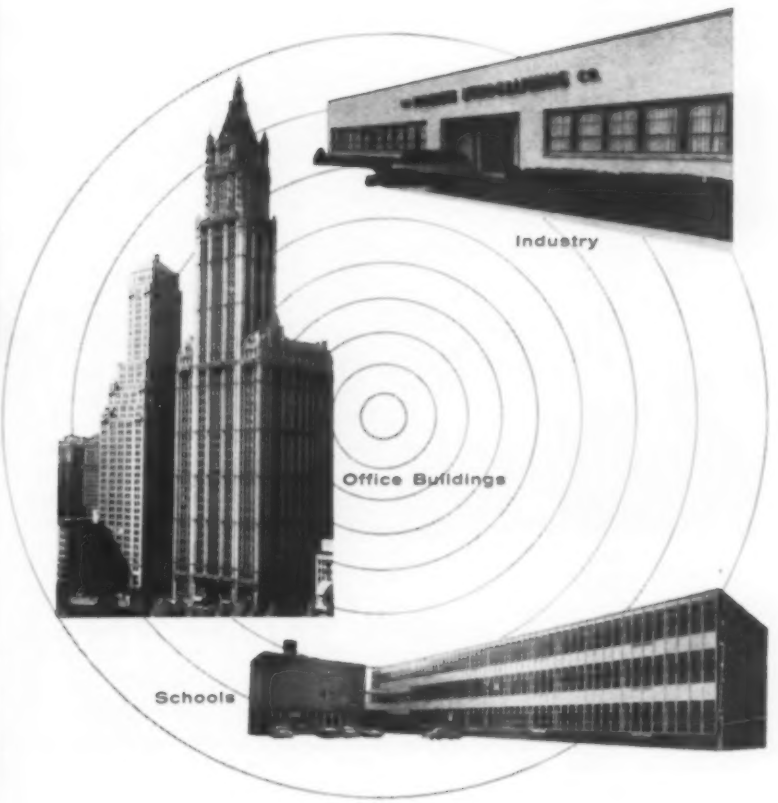

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The overhead fixture measures 72 by 18 inches and can be lighted all at once, as shown here, or in three sections. The light is diffused through a plastic lens.

George Cobb
Frank F. Morin

Ceiling Fixture Solves Three-Way Problem

WHEN Peninsula Hospital, Burlingame, Calif., first opened in March 1954, the lighting in patient rooms was thought sufficient to serve and please the patients, doctors and nurses who use the lights. In the planning stages of our construction more than 50 different types of patient room light fixtures were examined and tested before one was adopted.

The authors are, respectively, maintenance superintendent and administrative resident, Peninsula Hospital, Burlingame, Calif.

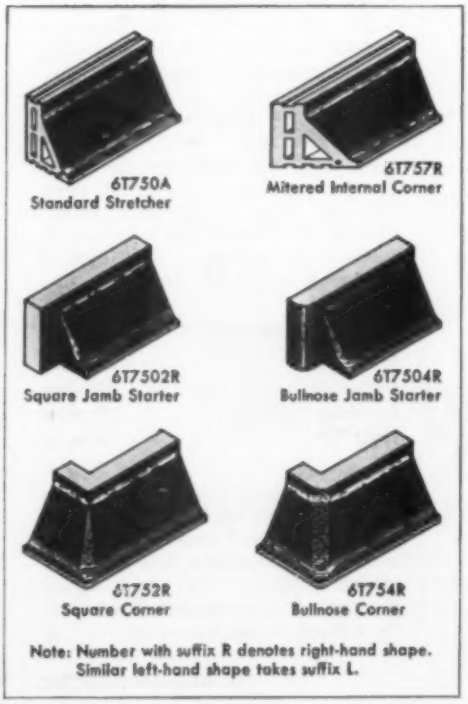
In our original construction, the wall mounted bracket type of fixture was selected and placed in a central location above the patient's bed. However, during four years of operation, it became apparent that the light we thought was the best available had not lived up to its expectations. Many patients complained that the supply of proper reading light was inadequate, and some patients even contemplated bringing table lamps from their homes. Doctors and nurses also found it difficult to perform their duties with the lights that were available.

Portable lights were provided whenever necessary; however, portable lights, whether they are temporarily attached to the bed or are floor lamps, are subject to breakage, interfere with the free movement of the bed and personnel, and occupy valuable space in an already crowded room. Portable lights are never in the area where they are needed and

Below, left: The section at the head of the bed is the patient's reading light. This section has two 15 watt, 18 inch lamps plus a 14 watt, 15 inch lamp in the center.

When the patient is ready to sleep, the foot section of the fixture can be used as a night light. It has a 6 watt incandescent lamp controlled from the entrance to the room.

Now splayed base shapes in NATCO ceramic glaze Vitritile, 6T series



Note: Number with suffix R denotes right-hand shape. Similar left-hand shape takes suffix L.

New units enhance appearance... prevent wall damage

Now Natco furnishes a full range of splayed base tiles designed for use in conjunction with walls of Natco ceramic glaze Vitritile. Ideal for use in hospitals, schools and other institutions where wheeled equipment is used, Natco splayed base shapes prevent damage to the wall surfaces.

Furnished in all standard colors and in the shapes shown at left, Natco splayed base shapes provide an attractive, practical way to retain the building's new look in the years ahead.

They are produced for use in conjunction with standard 6T service stretcher units ($5\frac{1}{16}$" x $11\frac{1}{4}$" face sizes). Overall height of base units is $5\frac{13}{16}$".

For complete information, write for Bulletin No. 75TA-M5.

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valuable time is lost in locating and transporting them.

The night light originally was thought to be adequate, but it also proved unsatisfactory. This light was installed several inches above the floor adjacent to the entrance, and whenever the light was switched on a glow was cast on the polished floor which caused a reflection in the patient's eyes, yet did not provide proper illumination beyond one or two feet from the door.

Therefore, when we began to plan for expansion, much time was spent in research for a light fixture that would incorporate all of our needs. First, we wanted a light that would provide sufficent reading light, yet not shine or glare objectionably in patients' eyes. Second, we wanted a light that would illuminate as much of the bed as possible whenever a doctor wished to examine a patient or when a nurse was required to administer an I.V. Third, we wanted a night light that would illuminate the room properly with minimum disturbance to the patient. We were unsuccessful in our search. Although much progress has been made in electrical fixtures during the postwar years, no adequate method of lighting has yet been developed to suit our needs. To solve the problem we decided to design our own fixture. After weeks of experimenting, one fixture was adopted. A local electrical firm manufactured and installed it in the hospital for final approval.

The fixture we adopted is 18 inches wide by 72 inches long, recessed and installed in the ceiling above the patient's bed. It has three sections:

1. One section, at the head of the bed, is the patient's reading light. It has a three-position switch at the end of the cord, which in turn is connected at the wall or gang plate for the patient's control. This section of the fixture has two 15 watt, 18 inch fluorescent lamps, plus an additional 14 watt, 15 inch fluorescent lamp in the center. The 14 watt fluorescent lamp is to be used for general lighting. If the patient wishes more illumination for reading purposes, the two 15 watt lamps may be switched on to give approximately 35 footcandles, slightly above the recommended number of footcandles for reading.

2. The center section is the doctor's examining light. It has a mercury switch located on the wall at the head of the bed, but not included in the wall or gang plate, and two 40 watt, 48 inch fluorescent lamps that produce 52 footcandles the full length of the bed. The physicians believe this light is more than adequate.

3. The foot section of the fixture is used as a night light. It has a 6 watt incandescent lamp that is controlled at the entrance of the room which furnishes sufficient illumination without disturbing the patient. There is one switch for each fixture in the room.

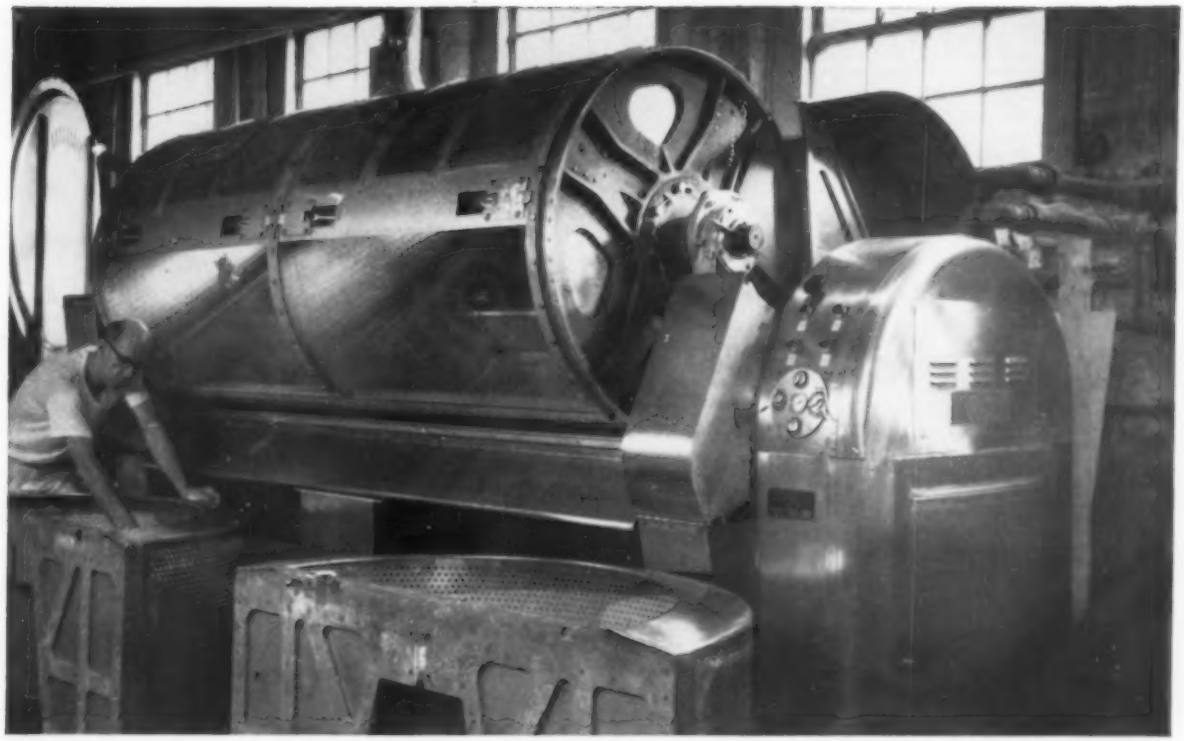
The light from the entire fixture is diffused by a single plastic lens with a small egg crate design, which concentrates the light on the bed area and gives the entire fixture an up-to-date appearance.

Although the initial installation of fluorescent tubes is somewhat more expensive than incandescent bulbs, the cost is recovered by reduction in maintenance expenses. (See current consumption schedule below.)

CURRENT CONSUMPTION SCHEDULE

Reading light	38 watts
General light	20 watts
Examining light	92 watts
Night light	6 watts

Patients, doctors and nurses have expressed their approval of our experimental patient room light, and we feel we have accomplished its intended purposes. This light fixture has proved so successful that it will be utilized in our expansion. #



Boston Children's Medical Center reports:

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ATTENTION

Nowhere is the control of cross-infection more important than it is in a lying-in hospital, and the housekeeping staff of Boston Lying-In is dedicated to the proposition that

Sanitation Is a Lifesaver for Babies

AMONG the most effective technics designed to aid cross-infection control are those used at Boston Lying-In Hospital, an institution devoted almost exclusively to obstetrics. With 6025 babies born in the 203 bed hospital last year, sanitation procedures are so important that they are explicitly interpreted to housekeeping department personnel in the training program and in sanitation memorandums distributed by Antoinette M. Stafford, executive housekeeper.

"Consistency in procedure," says Mrs. Stafford, "is one of the biggest deterrents to cross-infection."

Under the direction of Mrs. Stafford and Louis H. Hough, superintendent of plant, the program is designed to assure uniform adherence to sanitation methods proved effective in other hospitals and in Boston Lying-In, one of seven major teaching hospitals of the Harvard Medical Center.

A staff of 66 employes, five of whom are on call, make up the housekeeping department under Mrs. Stafford, including five assistant housekeepers, 27 maids, four seamstresses, one uniform room attendant, one bathroom attendant, 18 housemen, one rubbishman, one iceman, two wall washers, and one delivery room floorwasher. Four of the housemen work the night shift.

Each new employe is trained by one of the five assistant housekeepers, who uses orientation sheets to explain a new employe's duties and tours the work area with the employe to acquaint him with the facilities. Technics are demonstrated to each employe and a sheet of written instructions is issued. In addition, written memorandums are posted on doors in utility areas so that older employes can refresh their memories and newer ones can refer to the correct procedures.

Typical of the meticulous attention to sanitation detail carried out throughout the hospital are the cleaning methods employed in isolation areas of the recently opened Fuller Pavilion for surgical gynecology patients, in nurseries, and in discharge cleaning of rooms and wards. In the isolation area of the Fuller Pavilion, delivery rooms and operating rooms, a strong disinfectant solution is used to wash all floors because of its germ-killing properties. In making the solution, housemen mix 1¼ to 2 ounces of the disinfectant and one cup of detergent to two gallons of cold water.

These critical areas, including the nurseries and isolation areas, are washed with the solution once a day by maids. Delivery rooms are washed thoroughly with the solution after every delivery by one houseman, who devotes his time exclusively to washing delivery room floors.

In each case, floors are washed thoroughly with a clean mop, the mixture being used only for one floor

Below: Houseman keeps equipment to one side as he cleans the corridor.

Checking and supervision are the essence of good housekeeping. Here a supervisor inspects a patient's room and checks off work on her room check list.

New therapeutic beauty in quiet melamine dinnerware that's hard to chip, crack or break. Regal De Luxe is so durable it will save you up to 80% in replacement costs every year. It's made to take abuse . . . but at no sacrifice of beauty. An *exclusive* "color-on-color" process bonds two colors into a single piece. Colors are molded in . . . won't fade or wear off. All pieces have the self-draining contour base and heavy-duty rolled edges. Solid colors and decorated patterns also available. For price information and catalogs, write:

COLORS: Tan banded with Sepia; White banded with Burgundy, Bermuda Coral or Sage Green.

TRIPLE DUTY: Textured colors Green and White banded with Sage; Blue and White with Turquoise; Tan and White with Sandalwood.

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PRECAUTION TECHNICS IN DAILY ROUTINE CLEANING

Equipment and Supplies: All Equipment and Supplies Are to Be Kept in Sterilizing Room Contained in Isolation Area and Are Not to Leave This Unit.

Paper supply for day only
Germicide
Paste cleaner
Sterile soap
Disinfectant
Clean rags
Precaution laundry bags
White pail
Mop pail and wringer
Mop head
Mop handle

1. Close isolation door.
2. Wash hands well with germicide.
3. Put on mask, gown and cap before entering isolation unit. These will be found on linen truck. Mask should be put on first, covering nostrils and mouth. Mask should not be dropped around the neck and later reapplied. No mask should be worn longer than 45 minutes. Put on gown and fasten at back of neck and waist. Put on cap, covering all hair.
4. Bring into sterilizing room paper supplies to be used for daily refill.
5. Prepare water in mop bucket: 2 gallons of cold water, add 1 bottle of germicide (2 oz.). Stir thoroughly.
6. Moisten clean dust rag with solution and damp-dust window sills, venetian blinds, window frames, ledges on doors, cubicle frames, and so on, in individual unit. If bed is up against wall, damp-wipe wall. Damp-wash wall on either side of toilet seat in unit. Discard rag in precaution laundry bag and set bag in corridor.
7. Using clean mop wash floor with germicide solution in unit and bathroom connected with unit.

Bathrooms

1. Wash handbowl and toilet bowl with paste cleaner and sterile soap inside and out.
2. Wipe down all chrome and pipes, wastebasket outside, soap dispenser, towel dispenser, and so on, with sterile soap. Wipe with clean dry dust rag. Discard rag in precaution laundry bag which was set in corridor.
3. Close bag containing waste in wastebasket and discard into paper carton, cover with newspaper. Paper carton remains in corridor. (Rubbish man will pick up carton at completion of all cleaning about 9 a.m.)

SPECIAL REQUESTS TO HOUSEKEEPING STAFF

1. Report to housekeeping office at 7:30 a.m. each work day for assignments. All housemen are to report to building housekeeper at housekeeper's office each work day after lunch, and after completion of each assignment.
2. Keep a neat appearance. Remember, you help to represent the hospital to the patient and visitor.
3. Report defective or missing equipment, and also loose or missing door handles, door checks, dresser knobs, worn wiring, burned out bulbs, running faucets, loose fixtures, window screens, and so on.
4. Be sure ladder rests on a secure base. Do not stand on top step. Do not rest tools or articles on top of ladder.
5. Do not place tools or articles on top of lockers or places from which they can fall.
6. Do not put bare hands into places you cannot see. Do not empty wastebaskets by digging into them. Hold them by the sides and turn them upside down over a trash can or newspaper.
7. Wear gloves when you use steel wool. Wear gloves when washing walls.
8. Do not pick up broken glass, sweep it up—and at once. Pick up fine splinters and chips with a damp paper towel—then discard towel.
9. Take personal responsibility for seeing to it that slipping or tripping conditions anywhere on the floors or on stairways are either reported or taken care of at once. Pick up at once such articles as rubber bands, clips and so on.
10. Follow closely the instructions your supervisor gives you on the treatment of each type of floor, on cleaning furniture, windows and so on. Having the right materials is not enough. They must be applied correctly to be safe. The right way is the safe way.
11. Do not stand on tub sides to change shower curtains. Use a stepladder or a wide base stool.
12. Unplug electric lamps before wiping with a dry-damp cloth.
13. Utility closets should be organized and kept in a specified fashion with designated spaces. Leave equipment in order and clean and in its proper place before leaving each work day. Report all necessary repairs to equipment at once.
14. Cleaning equipment wire should not cross aisles or doorways at any time. Keep electrical equipment plugged in on the side of the space you are working on.
15. Keep a "safe side" on a corridor or room when washing or waxing. Put up warning sign so that people know you are there. Keep all your equipment on side being cleaned, not on "safe side." Stay in area until entire floor is safe and dry. Ask people to walk on dry side.
16. Remove wet mops from rooms and public areas when your mopping is completed. Do not block doorways or elevator entrances with cleaning equipment.
17. With cleaning equipment or supply trucks stay to the right. Go slowly near stairways, corridor intersections, elevators and down ramps. Do not leave equipment where anyone can trip over it or bump into it.
18. If you have an accident, no matter how slight, or if you become ill while working, please notify your building housekeeper at once.
19. Do not smoke in patient areas.
20. Be observant of the safety hazards about you. You may be able to remedy an unsafe condition.
21. The housekeeping office is open at all times during the work day to any employe who wishes to discuss any of his or her problems.

area and thrown away immediately. Mops and pails are washed immediately in another solution of disinfectant, detergent and water and hung up to dry, the mop heads being covered with sterile paper bags to assure that no germs inadverently come in contact with the mop head.

Sterilizing rooms within isolation areas are serviced once a day by maids, who make sure that supplies include: one day's paper supply, disinfectant, bleach, sterile soap, scouring paste, clean rags, precaution laundry bags, a white pail, a mop pail and wringer, a mop head, and a mop handle. "Precaution technics in isolation areas," says Mrs. Stafford, "leave nothing to the imagination of housemen or maids. We list everything for them in the memorandums and do all possible to impress upon them the importance of adhering to these instructions, without any innovations whatsoever."

Housemen and maids don masks, gowns and caps, with all hair covered, and wash hands with a germicide before entering these isolation areas. They are cautioned not to drop masks around their necks and later reapply them, or to wear masks longer than 45 minutes before changing.

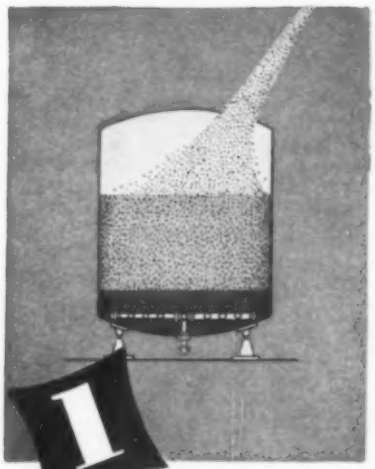
In addition to washing floors in the isolation areas once a day, maids and housemen use clean dust rags moistened with the disinfectant solution to wash window sills, venetian blinds, window frames, ledges on doors, and cubicle frames in each individual unit. If beds are located against a wall, the wall is damp-wiped by the houseman. Walls on either side of the toilet and the toilet seat are damp-washed. The rags are then discarded in a precaution laundry bag.

Isolation bathrooms also get meticulous attention once a day by a maid, who washes hand bowls and toilet bowls with scouring paste and sterile soap inside and out and wipes down pipes, wastebasket exteriors, soap dispensers, and towel dispensers with sterile soap. These are then wiped with a clean, dry dust rag, which is discarded in the precaution laundry bag.

Once a day, either in the afternoon or the evening, when babies are taken out of the nursery and brought to their mothers, the nurseries are thoroughly cleaned by housemen and maids, utilizing the same sterile sanitation procedures employed in isolation areas. Wearing precaution gowns and masks, one houseman and one maid thoroughly clean one nursery, washing the inside and outside of nursery windows and sills.

Discharge cleaning in isolation areas, rooms and wards is another area demanding close attention and supervi-

Three Ways to Get MORE SOFT WATER



By Refilling Your Water Softener With New High Capacity Elgin Zeolite you can get 3 to 10 times more soft water.

Think of it, from 3 to 10 times more soft water from your present water softener by simply refilling it with one of Elgin's new high capacity zeolites. Here is a dividend-paying investment you can't afford to pass up. In addition, regeneration will be required less frequently with savings in regeneration time and salt costs.

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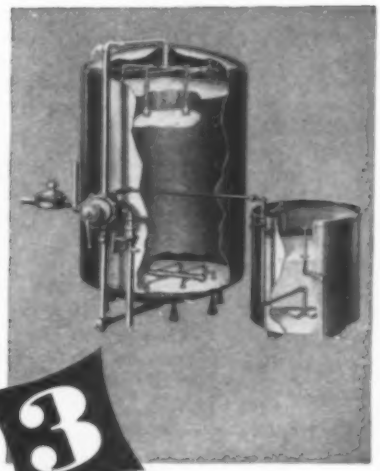
The ingenious Elgin "Double-Check" manifold system makes it possible to place far more zeolite in a water softener and to utilize it more efficiently. Capacity increases of as much as 44% can be secured. Loss of costly zeolite will be prevented too. Higher brining and backwashing efficiencies will be obtained. Here is another low cost answer to the need for more soft water.



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ELGIN DEALKALIZERS prevent corrosion of steam and condensate lines the basic economical way. Savings in piping, repairs and chemical treatment expense pays Dealkalizer cost many times over.

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sion at Boston Lying-in. Last year, with 7665 adult admissions, a correspondingly large number of discharge cleaning operations were carried out by the housekeeping department.

When a patient is discharged from the isolation unit, the nurse in charge notifies the housekeeping department. A maid then does routine cleaning, removing bedside curtains, draperies and linens, all of which are placed in the precaution laundry bag, and washing down bedside tables, bed frames, chairs, mattress covers, and any other furniture in the unit. After the floor has been routinely washed by the houseman, the maid hangs clean draperies and bedside curtains.

When a patient is discharged from an isolation area that has been grossly contaminated, the charge nurse notifies the building housekeeper and requests that the walls be washed with disinfectant. A houseman washes the walls before the maid enters the room to take care of routine duties.

When patients are discharged from private rooms and wards, everything movable is taken from the room by a houseman and washed with a detergent solution by maids. The houseman washes walls, windows and floors, which are then waxed and buffed. Even cotton fabric draperies are changed.

So that there will be no chance of omitting any procedure in the cleaning of discharge rooms, an assistant housekeeper enters the finished room and checks off everything that has been done on a master check sheet before a new patient is admitted. In fact, no patient is admitted to the room until the check sheet, properly filled out, is submitted to the administrative office. These check sheets are used for all areas of the hospital.

With most hospital stays of new mothers predictably short, averaging about seven days, ward discharge and sanitation and maintenance are relatively easy, according to Mrs. Stafford. When the ward is emptied completely —no new mothers are admitted after it is once filled—two housemen and one maid devote themselves to discharge cleaning. The housemen move all furniture out of the room, wash the floor and walls with a detergent solution, and then return furniture to the room after it has been washed down by the maid. As in the private rooms, draperies and curtains are replaced with freshly laundered materials.

Dust-mopping of floors is nonexistent in the hospital. "All that does is spread dust from one room to another," says Mrs. Stafford. "We prefer to vacuum the rooms and corridors and get rid of the dust completely."

Maids vacuum halls, rooms and wards once a day, working around patients or in the rooms when the patients are getting sun on adjacent patios.

One bathroom maid is charged with servicing all community and private bathrooms, servicing each four times during every day and twice in the evening for a total of six times each 24 hours. Her function includes washing toilet seats, toilets, wash bowls, and windows on the inside only. Toilet paper boxes are filled and sanitary pad containers emptied by the maid, with faucets, pipes, metal fixtures, and mirrors polished when necessary.

Because it is almost exclusively a lying-in hospital, according to Mrs. Stafford, with no control over when patients in labor will be admitted, deliveries may range from as few as six one day to as many as 25 the next. For this reason, within 10 minutes after a mother delivers her baby, the delivery room is stripped by the nurse on duty and the floor is washed with disinfectant solution by the delivery room houseman. Emphasis is put on completely sanitizing the delivery room as fast as possible at the hospital, with delivery tables and other fixtures also cleaned with sterilizing solutions by a maid.

(*Continued on Page* 118)

Maids and housemen wash corridors once a day and buff light coats of wax that are applied weekly with steel wool buffing machines. Night crews take care of the lobbies in the evening.

An unusual feature of the hospital is that it does not smell like a hospital. "We use no disinfectants or deodorants to cover up other odors," says Mrs. Stafford. "We just keep everything spotlessly clean, thus providing the best odor of all."

In addition to work areas already described, housekeeping employes are assigned duties in other areas, so that the entire hospital is covered. For example, the maid working in Suite No. 2 in Richardson House also is assigned to "dust anestheologist office and empty wastebasket" and other similar duties in various near-by rooms. Houseman No. 1, in addition to regular duties, is assigned to "clean Dr. Romney's and Dr. Reid's office every Sunday morning" and to "clean railings on stairways with damp dust cloth every day."

Doctors' and nurses' quarters are cleaned daily by housemaids and housemen who are given memorandums covering these duties in minute detail.

The maintenance department of the hospital, also under Mr. Hough's direction, figures prominently in discharge procedures. Just as the assistant housekeeper uses a check sheet to see that rooms are properly cleaned, the maintenance man has a check sheet of 50 items, including lamps, springs and plugs, which he uses in checking out each room.

Attention is focused on general maintenance, according to Mr. Hough, because the hospital is a maternity hospital. He says, "Patients coming to the hospital are, as a rule, not very sick. They are here because they want to be—to bear their babies—not because of uncontrolled circumstances, such as being involved in accidents, as in a general or city hospital.

"For that reason, most mechanical problems we handle with our own crews, there being no complex apparatus, crutches, braces or frames to be repaired."

The department includes 15 men, including two carpenters, two painters, steam-fitters, general mechanics, and a "Mr. Fixit," who devotes himself exclusively to repairing little things that often are overlooked, such as squeaking doors, tight bureau drawers, and burned-out light bulbs.

Painters are transferred from one area to another, covering areas that are most in need of attention with a flat nonglare paint in a variety of colors. The paint is easy to clean and is washed often by one houseman, using a paint cleaning machine.

The hospital buys steam from Harvard Medical School, across the street, thus paying only for the steam used and being relieved of the necessity of employing a foreman. One of the few outside agencies employed by the maintenance department is that of exterior window washers.

The maintenance department also is charged with keeping power doors on the delivery floor in constant operation. These doors are activated by nurses or orderlies with the touch of an elbow to a wall button. They swing open to allow beds to be rolled through with ease. Pedestrian doors, used exclusively for people walking through without stretchers, beds or other loads, are located immediately beside the power doors.

"Because we carry on a continuous and intensive research program for the better care of mothers and their babies in our own research laboratories," concludes Mrs. Stafford, "we always have our eyes open for new and better housekeeping and maintenance procedures. This is in keeping with our program of safety first, not only for mothers and babies, but all hospital personnel and visitors." #

Fast...efficient...quiet cleaning

Here are the only scrubbing machines and vacuum cleaners specially designed for use in hospitals.

Quiet. The MULTI-CLEAN Hospital Scrubbing Machine and Vacuum Cleaner are both equipped with *super-silent* motors to make them quietest on the market.

You can clean *anytime* with the MULTI-CLEAN Team . . . even at night . . . with little chance of waking or disturbing patients. Operation of radio, television, X-ray or other electrical equipment isn't affected, either.

Gleaming white. MULTI-CLEAN Hospital Scrubbing Machines and Vacuum Cleaners are the only ones on the market that are available in gleaming white and chrome finish to reflect the spotless sanitation and cleanliness of your hospital.

And aside from its quietness and appearance, this efficient MULTI-CLEAN Hospital Cleaning Team allows you to maintain highest standards of floor beauty and sanitation *with far fewer hours of cleaning time.*

Hospital Scrubbing Machine is a big time-saver for polishing, waxing, buffing, steel wooling, as well as scrubbing hospital floors. Workers finish the job in far less time because easy finger-tip controls and the adjustable handle lessen operation fatigue. The white enamel, 3½-gallon solution tank won't spill even when tipped.

Hospital Vacuum Cleaners with either 10 or 16 gallon tanks, have powerful suction which picks up scrub water in a fraction of the time *and far more completely* than is possible with old fashioned hand mop and wringer method.

With Heavy Duty General Electric Motors, stabilized motor brushes, and "magic-eye" electronic shutoff, your MULTI-CLEAN Hospital Vac is built to stay on the job year-after-year without a minute lost for mechanical upkeep!

If your Hospital hasn't yet adopted the famous MULTI-CLEAN METHOD of mechanized floor care, ask your MULTI-CLEAN Distributor for a demonstration and free floor survey . . . or mail coupon for more information. You'll be under no obligation.

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Physicians' Ledger Makes Staff Activity a Matter of Record

(*Continued From Page* 70)

formance on the medical staff in concrete terms.

2. Helps Joint Commission examiners to see when attendance requirements are being met.

3. Affords complete records of attendance with authentic signatures.

4. Aids in establishing awareness among medical staff members that their participation in hospital activities does not go unnoticed.

5. Aids in assigning members of the staff to various standing and special committees.

6. Shows which meetings are drawing the most interest, very graphically.

7. Shows which physicians are obtaining autopsies and which may be lax in that regard.

8. Indicates graphically which physicians are using hospital beds.

9. Indicates who is carrying the load in the OPD and on hospital teaching service.

10. Assists division chiefs, administration and board in making yearly appointments to the staff.

11. Indicates interest shown by various sections and divisions in hospital affairs.

The amount of information recorded can be expanded or reduced to meet the needs of the individual hospital. The "ledger sheet" described contains space for four fiscal years, after which time new sheets must be prepared.

This paper has discussed the merits of the performance review method of evaluating individual physicians for reappointment to the medical staff. It is a guide to aid the board of trustees and the medical advisory committee to evaluate less haphazardly the contributions made to the hospital by physicians in a given period.

Our feeling is that a reliable system for making appointments or reappointments to the medical staff is through the use of *recorded evidence*. However, whether it be in the form of a "Physicians' Ledger" as described here, or in some other form, the important thing is that it be recorded.

The time and effort expended in maintaining the Physicians' Ledger is worth while. This permits an examiner to visit a hospital and audit the medical staff in somewhat the same manner the C.P.A. audits the accounts of a business enterprise, for the quantitative service review, plus the medical audit, give what we believe to be a most complete and comprehensive portrait of a hospital's professional activities. #

Key to Preserving the Voluntary Health Principle

(*Continued From Page* 83)

subscriber pays the first portion of his hospital bill (a $25 deductible is typical), are intended to reduce utilization and eliminate small claims that may be disproportionately costly to process. Ten plans employ deductibles; in three of them, the group member is favored over the nongroup member.

Although relatively few of them use this mechanism, a third of the plan administrators believe it to be necessary and desirable in nongroup enrollment. Another third regard it as necessary although not desirable. Of the remainder, 19 per cent view deductibles as desirable but not necessary, and 16 per cent as neither necessary nor desirable. More than 80 per cent of them do believe that the deductible decreases faulty utilization.

With coinsurance the subscriber pays some fixed percentage of his total hospital bill. Five plans use some coinsurance provision, four of them favoring group members in applying it. As with deductibles, a much larger percentage of the administrators favor coinsurance than use it. Thirty-eight per cent hold that it is both necessary and desirable in nongroup enrollment. Eleven per cent believe it is desirable but unnecessary. Twenty-nine per cent consider it necessary but not desirable, and 22 per cent believe it is neither. About half of the administrators believe that coinsurance provisions would decrease a plan's effectiveness in attracting new subscribers and in retaining old ones. A large majority, however, feel that it would reduce faulty use of services.

Aside from group conversion or "left employ," which is used by all Blue Cross plans to enroll nongroup members, the plans use variations of five different means of reaching and enrolling individuals.

A number of plans have used community enrollment campaigns to extend coverage to the nongroup population. These campaigns may or may not require that some fixed percentage of the community enroll before the community is eligible for coverage.

Community enrollment that requires participation by some fixed percentage of the population has been relied on less and less by the plans, and is now used by only five plans. Whatever success plans have had with this approach has been in small areas which are nonurban and nonindustrial.

Community enrollment that does not require any set percentage of the population to enroll is considerably more popular among the plans. A quarter of the plans currently use it, most often in areas with fewer than 100,000 people.

Continuous enrollment of individuals—sometimes called "over-the-counter" enrollment—is used by about three-quarters of the plans. Continuous enrollment makes coverage to individuals available throughout the year. The way it is used varies greatly from plan to plan. In contrast with the two community enrollment methods, continuous enrollment seems to be less effective in low population areas.

A fourth enrollment method, the planwide open enrollment campaign, makes coverage available periodically to the entire nongroup population (sometimes to the entire population regardless of its group status) in the plan area, through an enrollment campaign, which generally lasts for 10 days or two weeks.

This enrollment approach is used today by a third of the plans. It has proved more successful in larger areas than in smaller rural communities.

With the exception of continuous enrollment, enrollment of nonemploye groups is practiced by more plans than any other approach: More than 60 per cent now use this method. Nonemploye group contracts are generally granted to associations of farmers, ministers, lawyers and members of other professional organizations or trade unions who, while not working for a common employer, can be treated as if they formed an employe group.

Administrators have generally focused enrollment efforts on the nongroup population as a whole. However, they have estimated which approaches are most and least successful with specific segments of this population.

Enrollment of nonemploye groups is regarded as the most effective method of reaching the rural farmer. Continuous enrollment and periodic planwide campaigns are regarded as the most effective means of reaching the aged and retired. Continuous enrollment and nonemploye group enrollment are considered the most effective way of reaching self-employed professional people.

For enrolling the self-employed in general and those working in small groups, continuous enrollment is again more highly favored than any other method. Apparently, this approach is regarded as the best to cover diverse, unorganized population segments. Community enrollment that requires a set percentage is regarded as the least effective means of enrolling all segments.

While they do not consider one approach as the solution to nongroup enrollment and others as worthless, the plan administrators have developed favorable and unfavorable attitudes toward the different approaches. Continuous enrollment is regarded as the most effective method over-all by 35 per cent of the plan administrators. Periodic planwide campaigns are regarded as the most effective approach by 20 per cent. On the other hand, community enrollment with a fixed percentage is felt to be the least effective enrollment method by a quarter of the administrators.

The group conversion privilege or "left employ" contract, offered by every plan, is a crucial inroad into nongroup coverage. Workers who become self-employed, temporarily unemployed, or engaged by firms where too few people work for a group contract continue to fill the nongroup population. Unless these people obtain a group conversion contract, their status makes them subject to less liberal benefits, higher cost, or complete exclusion from coverage. This is particularly true of those approaching or passing 65 years of age.

Among most plans there is considerably less differential treatment between the left-employ contract and the group contract than there is between the nongroup and group. Only 4 per cent of the plans have any special requirements for converting a group contract to a left-employ. Despite this, a large number of people fail to obtain the left-employ contract. Conversion from group to individual membership may well constitute one of the increasingly effective means of covering the nongroup population.

Vigorous application of this method and the other existing enrollment methods may enable many plans to extend coverage to large segments of the nongroup population. However, existing methods of enrollment should not be regarded as the only—or even the most effective—means of covering the millions of individuals without any form of protection or the many with inadequate protection.

In view of the necessity of covering the nongroup as rapidly as possible, some new approach might be devised to permit even larger segments of the nongroup population to be treated as groups. For example, persons holding life insurance policies in a particular company might constitute a group, as could those who have accounts at a given bank, or who pay telephone bills in one community. Whether or not this should prove possible, by pooling their experience, studying new approaches, and allocating more time and effort to enrolling the nongroup, Blue Cross plans can fufill even further their historic rôle in helping the American people meet the costs of hospital care. #

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A growing number of hospitals throughout the country—large and small—are protecting their patients against the serious consequences of commercial power failure by installing dependable CAT emergency power units. Caterpillar Diesel Electric Sets can be counted on to start up automatically, within seconds, and the safe storage of low-grade diesel oil is a plus factor to be considered.

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Sturdy Memorial Hospital	Attleboro, Mass.
Mass. Mem. Hosp.; Haynes Mem.	Boston, Mass.
Delaware Hospital, Inc.	Wilmington, Del.
Greenwich Hospital	Greenwich, Conn.
Mountainside Hospital	Montclair, N.J.
St. Francis Hospital	Buffalo, N.Y.
Northeastern Hospital	Philadelphia, Pa.
Goldwater Mem. Hosp.; N.Y.U. Bellevue Med. Ctr.	New York, N.Y.
U. S. Naval Hospital	Chelsea, Mass.
Rutland State Sanitorium	Rutland, Mass.
Mercy Hospital	Pittsburgh, Pa.
York Hospital	York, Pa.
Boston Childrens Hospital	Boston, Mass.
Leominster Hospital	Leominster, Mass.
Pittsfield General Hospital	Pittsfield, Mass.
Gen. Hospital of Monroe Co.	E. Stroudsburg, Pa.
West Jersey Hospital	Camden, N.J.
Grace-New Haven Comm. Hosp.,	New Haven, Conn.
Walter Reed Army Med. Center	Washington, D.C.

SOUTHEAST

Beckley Memorial	Beckley, W. Va.
Hazelwood T. B. Hospital	Louisville, Ky.
Piedmont Hospital	Atlanta, Ga.
Pineview General Hosp.	Valdosta, Ga.
Turner County Hospital	Ashburn, Ga.
Baptist Mem. Hospital	Jacksonville, Fla.
Mercy Hospital, Inc.	Miami, Fla.
Med. College of South Carolina	Charleston, S.C.
Richmond Memorial Hospital	Richmond, Va.
Man Memorial Hospital	Man, W. Va.
Camden Clark Mem. Hosp.	Parkersburg, W. Va.
Shenandoah C. Mem. Hosp.	Woodstock, Va.
Jackson Memorial Hospital	Miami, Fla.

CENTRAL

Toledo Hospital	Toledo, Ohio
Little Company of Mary Hosp.	Evergreen Park, Ill.
S. Chicago Comm.	Chicago, Ill.
Cole Hospital	Champaign, Ill.
Methodist Hospital	Peoria, Ill.
St. Joseph's Hospital	Elgin, Ill.
Veterans Administration Hospital	Hines, Ill.
The Suburban Cook Co. Tuberculosis Sanitarium District	Hinsdale, Ill.
St. Francis Hospital	Evanston, Ill.
The Mather Home	Evanston, Ill.
Pekin Public Hospital	Pekin, Ill.
Proctor Community Hospital	Peoria, Ill.
Passavant Mem. Hospital	Jacksonville, Ill.
St. Catherine Hospital	E. Chicago, Ind.
St. Margaret Hospital	Spring Valley, Ill.
Galesburg State Research Hosp.	Galesburg, Ill.
Peoria County Nursing Home	Peoria, Ill.
Oak Knoll Sanitorium	Mackinaw, Ill.
Monmouth Hospital	Monmouth, Ill.
Peoria Municipal T.B. Sanitarium	Peoria, Ill.
Mercer County Hospital	Aledo, Ill.
Knox County Nursing Home	Knoxville, Ill.
St. Louis County Hospital	Clayton, Mo.

PLAINS

Bishop Clarkson Mem. Hospital	Omaha, Neb.
Logan Latter Day Saints Hospital	Logan, Utah
Univ. of Kansas Med. Center	Kansas City, Kan.
Clay County Hospital	Clay Center, Kan.
Immaculate Conception Mis. School	Stephan, S.D.
County of Nevada Hospital	Nevada City, Calif.

WESTERN

St. Elizabeth Hospital	Yakima, Wash.
Yakima Valley Mem. Hospital	Yakima, Wash.
Trinity Hospital	Arcata, Calif.
Valley Children's Hospital and Guidance Clinic	Fresno, Calif.
Highland Alameda Co. Hosp.	Oakland, Calif.
General Hospital, Ventura Co.	Ventura, Calif.
St. Labre Indian Mission	Ashland, Mont.
Providence Hospital	Anchorage, Alaska
St. Joseph's	Fairbanks, Alaska
Good Shepherd Mission	Fort Defiance, Ariz.

CANADA

Workmen's Compensation Board	Toronto, Ont.
Royal Alexandra Hospital	Edmonton, Alta.
Newfoundland T. B. Association	Newfoundland
Provost Mun. Hospital Dist. No. 12	Provost, Alta.
Esperanza Hospital	Esperanza, B.C.
Kamsack Union Hospital	Kamsack, Sask.
Regina General Hospital	Regina, Sask.
Scarborough Gen. Hospital	Scarborough, Ont.
Sudbury Mem. Hospital	Sudbury, Ont.
Toronto Western Hospital	Toronto, Ont.
Hotel Dieu de Saint Joseph	Campbellton, N.B.
St. Peters Hospital	Melville, Sask.
University of Alberta Hospital	Edmonton, Alta.
Saskatchewan Anti Tuberculosis League	Saskatchewan

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NEWS DIGEST

Preventive Care to Be Goal of Hospitals, Mid-Atlantic Group Hears . . . Strike Ends at Swedish Hospital, Seattle . . . Student Nurses Should Not Have "Regular" Duty, A.N.A. Convention Told . . . Columbia University to Survey 19 New York Health Plans

Preventive Care Must Be Goal of Hospitals in Future, Middle Atlantic Assembly Hears

ATLANTIC CITY, N.J.—The health care of the future will be preventive health care, practiced to a large extent in our hospitals, delegates to the 10th annual meeting of the Middle Atlantic Hospital Assembly, May 21 to 23, were told.

Some 4000 hospital representatives from New York, Pennsylvania and New Jersey attended the convention.

Dr. Theodore G. Klumpp, president of Winthrop Laboratories, New York, predicted that "the next great medical crusade will be directed toward the control of environmental factors and patterns of living and behavior that predispose to disease and injury.

"It appears inevitable that the broadest spectrum of scientific theory and technology will be increasingly applied to the solution of medical problems," Dr. Klumpp said, adding that the meeting place for experts in technical fields will be the hospital of the future. More and more patients will be referred to hospitals for investigation, study and treatment, he said.

Dr. Klumpp discussed leading problems in medicine, including arteriosclerosis, cancer and mental illness, and the progress being made toward conquering them, mentioning improvement in surgical technics and pharmaceuticals as reasons for the continued advance.

"By emphasizing preventive medicine, rehabilitation and the care of the ambulatory patient, the demand for beds in general hospitals can be reduced and the cost to many patients lowered," Dr. Aims C. McGuinness, special assistant to the secretary for health and medical affairs, Department of Health, Education and Welfare, told the delegates.

Chronic disease hospitals, nursing homes, expanded outpatient departments, and diagnostic and treatment centers will help cut down on the costs of long-term care and reduce the need for general hospital beds, Dr. McGuinness said.

Preventive medicine will be the most effective method of solving the problem of health care for the aged, commented Dr. Edward L. Bortz, chief of medicine at Lankenau Hospital, Philadelphia, and past president of the American Medical Association. Dr. Bortz is a member of the A.M.A.'s committee on the aged.

Officers of the Middle Atlantic Hospital Assembly, left to right: secretary, J. Harold Johnston, executive director, New Jersey Hospital Association; president, Dr. A. P. Merrill, director, St. Barnabas Hospital, New York; treasurer, John F. Worman, executive director, Hospital Association of Pennsylvania, and vice president, James C. Kirk, Pottsville Hospital, Pottsville, Pa.

The major effort should be toward the achievement of positive health to keep the older persons out of hospitals, not toward making hospitalization so financially advantageous that older persons will, in effect, be invited into the hospitals, Dr. Bortz said.

The best solution, in labor's view, is social security, said Katherine Ellickson, assistant director of the department of social security of the AFL-CIO. Organized labor, she pointed out, is opposed to application of a means test in the provision of health care.

"Let us not forget that problems of the aged are acute. Too much study can mean too long delay for millions of men and women who eagerly await affirmative action," Mrs. Ellickson told her audience.

Dr. Edwin L. Crosby, director of

(*Continued on Page* 138)

Union, Swedish Hospital Accept Settlement Terms to End Three-Month Strike

SEATTLE.—Striking members of Local 301, Hospital Workers' Union, called off their strike against the 375 bed Swedish Hospital at noon on June 11.

Pickets who had begun to march before the hospital's entrances March 20 were withdrawn minutes later.

The strike ended after both the union and the hospital accepted a settlement proposal worked out by the King County Central Labor Council and the Seattle Hospital Council.

Arthur Hare, international representative of the Building Service Employes' Union, with which the local is affiliated, said the union members voted 8 to 1 to end the strike, which was started against the institution in an effort to enforce the union's demand for recognition as a bargaining agent of nonprofessional housekeeping, dietetic and nursing employes.

As part of the settlement, the union agreed to reimburse the hospital for about $500 of property damage. The hospital previously had submitted a "bill" to the union for $2,784.49 in damages.

Hare said the union, although not responsible for the damage, was making the payment as fulfillment of a "moral obligation."

The settlement agreement provided that employes who went on strike will be reemployed as soon as vacancies exist. The hospital planned to hire 10 immediately, and 70 others later; their jobs were taken by new employes during the strike.

Also provided for was an agreement that future labor relations will be handled by the hospital council, rather than individual hospitals. The hospital agreed to maintain minimum wages and working conditions previously in effect.

Another provision called for establishment by October 1 of a "Toledo Plan" recognizing a special bargaining status for hospitals, providing for a perpetual strike truce, and a permanent community committee to handle grievances.

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A.N.A. Deplores Use of Student Nurses by Hospitals for "Regular" Nursing Tasks

ATLANTIC CITY, N.J.—The increasing hospital practice of using student nurses to work as regular nurses threatens the health and welfare of the public, delegates to the American Nurses' Association were told here last month.

Also reported at the nurses' convention were statistical data that revealed variations in the average weekly earnings of general duty nurses from $72 in Chicago and San Francisco-Oakland to $56.50 in Philadelphia.

More than 7000 professional nurses and visitors attended the meeting, which was built around the theme, "The Professional Nurse: Practitioner and Citizen."

The association has found that student nurses are employed in hospitals in 35 of the 41 districts recently surveyed, officials reported. They asked the association to urge each state nurses' group to establish a committee to guard the public against such practices.

According to Mrs. Margaret F. Carroll, assistant executive director, it is impossible to determine exactly how many student nurses were employed, since they generally are carried on hospital employment rolls as "nurse's aides."

The salary report, compiled by the U.S. Bureau of Labor Statistics and titled "Facts About Nursing," covered directors and supervisors of nurses, nurse instructors, head nurses, and various other categories of hospital personnel as well as general duty nurses in 16 metropolitan areas.

Comparisons of professional nurses' salaries in the nongovernment hospitals with those of other women professional and technical employes showed that general duty nurses usually earn less than any of the other groups, with the exception of x-ray technicians in 10 of the 16 cities and medical technologists in six of the cities. Supervisors of nurses generally receive higher salaries than any of the other groups, with the exception of medical social workers in three cities, and medical record librarians in two cities the survey found.

Average weekly earnings of directors of nurses range from $120.50 in Minneapolis-St. Paul to $95.50 in Baltimore. For supervisors, the highest average weekly earnings were also in Minneapolis-St. Paul, $88, and the lowest in Philadelphia, $70.50.

Nursing instructors' highest weekly earnings, on the average, were found in San Francisco-Oakland, $92, and the lowest in Memphis, $71. Head nurses' salaries ranged from $81 in Minneapolis-St. Paul to $63 in Philadelphia.

An expanded program of research activities was proposed to delegates at the convention, and the first national conference on nursing research, to be held in September at Western Reserve University, was announced.

A new book, reporting on the A.N.A.'s current research program, was introduced. Results of 30 projects are included in the book, titled "Twenty Thousand Nurses Tell Their Story."

The association voted to increase yearly dues from $5 to $7.50.

Ruth B. Freeman, associate professor of public health administration, Johns Hopkins University School of Hygiene and Public Health, received the first Pearl McIver Public Health Nurse Award for outstanding service.

Ella Best, retiring executive secretary of the association, was honored at a program held June 12.

Practical Nurses' Program

NEW YORK.—Expansion of the program of the National Association for Practical Nurse Education, by the creation of a new division of services to state associations, was announced last month.

The division will be headed by an associate director of the organization who will be a licensed practical nurse. A second associate director, a registered nurse, will direct the division of practical nurse education.

Columbia to Undertake Rate Study of New York Blue Cross, Blue Shield

NEW YORK.—Columbia University's school of public health and administrative medicine will conduct a yearlong survey of the 19 Blue Cross, Blue Shield, and dental expense indemnity plans in New York State, it was announced by university officials last month.

Purpose of the study, which will be paid for by the plans themselves, is to determine equitable rates and revenues for the plans and their 12 million subscribers. Governor Harriman had asked the legislature to vote a $100,000 appropriation for a temporary commission to carry out such a study, but the lawmakers did not grant the money.

Services of Columbia faculty members will be free, but the plans will bear the expense of other experts and staff for the study. Dr. Ray E. Trussell, executive officer of the school of public health and administrative medicine, will direct the survey; Frank van Dyke, assistant professor of administrative medicine, will serve as associate director.

State Superintendent of Insurance Julius S. Wikler said: "It is our hope that the undertaking will provide a more accurate means of determining the cause of rising hospital costs, the need for possible changes in subscriber rate levels from time to time, the efficiency of the operations of the plans in general and what economies may be instituted effectively in the public interest."

STUDENTS AT COLUMBIA UNIVERSITY

Administrative residents in the class in hospital administration at Columbia University, left to right. Front row: Sister Gertrude Veronica; John A. Blake; Dorothy M. Gioielli; Dr. Clement C. Clay, associate professor; Dr. E. Dwight Barnett, professor; Dr. Magda P. Shorney, assistant professor; Margaret L. Beede; Robert K. Schwartz. Second row: Antonio Vega; Dr. Kiyoshi Iwasa, special student; Dr. Ekrem Okyay; Dr. Uri Khassis; Stanley C. Stevens; Joseph B. Smolens; George H. Petti; Saul Carb; John D. Tubbs. Third row: Ramon A. Rivera-Rivera; Aurelio Llado-Hernandez; Dr. Pascual Navarro; Marcelino Ramos; Richard S. Warren; Harry D. Gottschall; Silvio J. Pascal; Howard N. Newman; Walter R. Rentschler; E. Geoffrey High. Not shown: Eliseo Borrero, Rafael Bruno-Rivera, R. H. Simmons.

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GRADUATION TIME FOR HOSPITAL ADMINISTRATION STUDENTS

UNIVERSITY OF CHICAGO

Members of the class in hospital administration at the University of Chicago, left to right. Front row: Gerald B. Cole, Jerry L. Buckingham, Dr. Lauro Vivaldo-Fernandez, Dean E. Leiser, James R. Shawver, Jack C. Robinette. Second row: Thomas E. Coull, Lee Pridgen Jr., David L. Allen, William L. Boyd, Thomas J. Broderick, Alfred J. Sparkes Jr. Third row: So Zimmerman, coordinator; Vernon Forsman, associate director; Ray E. Brown, director; Irvin G. Wilmont, assistant director; James A. Connelly, assistant director; David M. Hatfield, assistant director.

UNIVERSITY OF MINNESOTA

University of Minnesota students in the class of hospital administration, left to right. Front row: Willis J. Hindman; Janet G. Brodahl; James A. Hamilton, director; Dr. Gaylord W. Anderson, director, school of public health; James W. Stephan, associate director; Edith M. Lentz, research director; Raymond E. Seaver; Thomas Q. Bergfald. Second row: Jack R. Fecteau; John P. Rugh; Victor M. Jaramillo; Michael M. Walker; John J. Rockwell; Paul H. Ward Jr.; Richard A. Cranford; Glen R. Clark; Gordon K. Flom. Back row: Cris A. Stang; William J. Hartung; Dr. Guillermo Fajardo-Ortiz; Thomas J. Campbell; Keith E. Ingbritsen; Roger E. Gurholt; Arvid B. Brekke; John S. Glass; Paul A. Teslow; Lawrence A. Hill.

NORTHWESTERN UNIVERSITY

Northwestern University students in the hospital administration program, left to right. Front row: Robert F. Gilmore, George W. Jackson, Morris Parrish, John Stocking, Ronald H. Wilson, Harry Eliazarian. Second row: Roger W. Wessli, John C. McGreevy, Jerome M. Kasdan, Selma N. Earle, Dr. Charles U. Letourneau (director), Laura G. Jackson (associate director), Frederick L. Gibson, Herbert P. Neef, Alan H. Toppel, Joseph A. Saunders. Third row: Edward L. Olson, P. R. Mariani, Lloyd J. Verret, Richard M. Warren, John H. Schill, William L. Benson, William J. Allen, Jack L. Samuels, Capt. W. F. Baker, Joseph L. Faletra, Roland E. Kohr, Gerald M. Krantz, James V. Dorsett Jr., Rolin H. Johnson, Louis J. Lonni, Robert A. Tittle, James Shepherd, Melvin A. Lyons. Last row: William D. Hilliard, Charles D. Holland, Robert E. Huesers, Don L. Arnwine, Frank Puntenney Jr., Leo Reich, James C. Ruthrauff, John P. Certo, Raymond W. Leitner, James R. Horton, Mark E. Wittock, Karl D. Glunz, Lt. John Frezza, Robert J. Aronne, John L. Stellner, Cyril H. Weagle Jr. Not in photograph, George Mancuso.

YALE UNIVERSITY

Class in hospital administration at Yale University, left to right. Seated: John O'Connor; Ellwyne D. Spiker; Dr. Albert W. Snoke, director, Grace-New Haven Community Hospital; George S. Buis, director, program in hospital administration; John D. Thompson, research associate. Standing: Dr. Kenneth J. Williams; Hugh J. Maher; Oscar W. Avant; John T. Foster; Lee J. Podolin; Dr. Leo De Larrea; Dr. Hugo Saenz.

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Northwestern University Assigns Students to Hospital Residencies

CHICAGO.—Students in hospital administration at Northwestern University have been appointed to the following administrative residencies:

William J. Allen to Southern Baptist Hospital, New Orleans; Don Lee Arnwine to University of Colorado Medical Center, Denver; Robert J. Aronno to Beth Israel Hospital, Boston; Capt. William F. Baker to USAF Hospital, Maxwell Air Force Base, Montgomery, Ala.; William L. Benson to Medical Center, Tyler, Tex.; John P. Certo to St. Francis General Hospital and Rehabilitation Institute, Pittsburgh.

James V. Dorsett Jr. to University Hospital and Hillman Clinic, Birmingham, Ala.; Selma N. Earle to Jackson Memorial Hospital, Miami; Harry Eliazarian to Hackensack Hospital, Hackensack, N.J.; Joseph L. Faletra to Newton-Wellesley Hospital, Newton Lower Falls, Mass.; Lt. John Frezza to USAF Hospital, Wright-Patterson Air Force Base, Dayton, Ohio; Frederick L. Gibson to Herrick Memorial Hospital, Berkeley, Calif.

Robert F. Gilmore to Clara Maas Memorial Hospital, Belleville, N.J.; Karl Dean Glunz to St. Joseph's Hospital, Milwaukee; William D. Hilliard to Fairview Park Hospital, Cleveland; Charles D. Holland to Baptist Hospital, Nashville, Tenn.; James R. Horton to Brackenridge Hospital, Austin, Tex.; Robert E. Huesers to Doctor's Hospital, Seattle. George W. Jackson to Veterans Administration Hospital, Houston; Rolin H. Johnson to Waukesha Memorial Hospital, Waukesha, Wis.; Jerome M. Kasdan to Mount Sinai Hospital, Chicago; Roland E. Kohr to Bethesda Hospital, Cincinnati; Gerald M. Krantz to Bridgeport Hospital, Bridgeport, Conn.; Raymond W. Leitner to Emanuel Hospital, Portland, Ore.

Louis J. Lonni to Highland Park Hospital, Highland Park, Ill.; Melvin A. Lyons to Providence Hospital, El Paso, Tex.; John C. McGreevy to Harrisburg Polyclinic, Harrisburg, Pa.; George P. Mancuso to Grant Hospital, Chicago; Peter R. Mariani to Community Hospital, Indianapolis; Herbert P. Neef to Silver Cross Hospital, Joliet, Ill.

Edward L. Olson to Swedish Covenant Hospital, Chicago; Morris H. Parrish to Memorial Hospital, Houston; Frank Puntenney Jr. to Columbus State Hospital, Columbus, Ohio; Leo Reich to Butterworth Hospital, Grand Rapids, Mich.; James C. Ruthrauff to Wesley Hospital, Wichita, Kan.; Jack L. Samuels to Mount Sinai Hospital, Milwaukee.

Joseph A. Saunders to California Hospital, Los Angeles; John H. Schill to Baptist Hospital, Pensacola, Fla.; James F. Shepherd to Flower Hospital, Toledo, Ohio; John Lee Stellner to Baptist Memorial Hospital, Jacksonville, Fla.; John H. Stocking to Rochester Methodist Hospital, Rochester, Minn.; Robert A. Tittle to Mount Park Hospital, St. Petesburg, Fla.

Alan H. Toppel to Chicago Wesley Memorial Hospital, Chicago; Lloyd J. Verrett to Ochsner Foundation Hospital, New Orleans; Richard M. Warren to Baroness Erlanger Hospital, Chattanooga, Tenn.; Cyril H. Weagle Jr. to White Cross Hospital, Columbus, Ohio; Roger W. Weseli to Good Samaritan Hospital, Cincinnati; Ronald H. Wilson to Gorgas Hospital, Canal Zone, and Mark E. Wittock to Veterans Administration Research Hospital, Chicago.

Yale Students Assigned to Hospital Residencies

NEW HAVEN, CONN.—The following residencies have been announced by the department of public health, Yale University School of Medicine, for its students in hospital administration:

Oscar W. Avant Jr. to North Carolina Baptist Hospital, Winston-Salem; John T. Foster to Stamford Hospital, Stamford, Conn.; Dr. Lelo De Larrea to University Hospital, Ann Arbor, Mich.; Hugh J. Maher to Lankenau Hospital, Philadelphia.

John F. O'Connor to Genesee Hospital, Rochester, N.Y.; Lee J. Podolin to Montefiore Hospital, New York; Ellwyne D. Spiker to New England Center Hospital, Boston; Dr. Kenneth J. Williams to Grace-New Haven Community Hospital, New Haven, Conn., and Dr. Hugo Saenz-Noguerol to Lima, Peru.

UNIVERSITY OF TORONTO

Students in the hospital administration class at the University of Toronto, left to right. Front row: R. B. Ferguson (lecturer), Dr. G. Harvey Agnew (professor and director), Eugenie M. Stuart (associate professor), Dr. J. W. Barr, Dr. W. D. Piercey. Second row: C. A. Meilicke, Sister Maria Loyola, Sister Ann Martin, J. F. Rafuse. Third row: Dr. W. S. Hacon, P. R. Carruthers, Mrs. D. W. White, G. F. McCracken, and R. L. Innes.

Residencies Announced for Toronto Students

TORONTO, ONT. — The following residency appointments have been announced for students in the program of hospital administration at the University of Toronto:

Dr. J. W. B. Barr to Kingston General Hospital, Kingston, Ont.; P. R. Carruthers to Winnipeg General Hospital, Winnipeg, Man.; Dr. W. S. Hacon to Toronto East General Hospital, Toronto, Ont.; R. L. Innes to Sick Children's Hospital, Toronto, Ont.; C. A. Meilicke to University Hospital, Saskatoon, Sask.

G. F. McCracken to Hamilton General Hospital, Hamilton, Ont.; J. F. Rafuse to Toronto General Hospital, Toronto, Ont.; Sister Ann Martin to St. Joseph's Hospital, Toronto, Ont.; Sister Maria Loyola to St. Michael's Hospital, Toronto, Ont., and Mrs. D. W. White to Crouse-Irving Hospital, Syracuse, N.Y.

ST. LOUIS UNIVERSITY HOSPITAL ADMINISTRATION STUDENTS

Front row, l. to r.: Associate Director C. E. Berry, Harold Hinderer, John T. James, Director Rev. John J. Flanagan, S.J., Sister Anthony Marie, Sister Mary Urban, Sister M. Coronata, Sister M. Aileen, Orlando R. Pozzuoli, Sister Rose Vincent, Sister Mary Kiernan, Sister M. Rita, Sister M. Bernardine, Sister M. Agnes, Sister M. Euphrasia, Sister M. Grace, Sister Mary Joan, Sister M. Raymond, Sister Mary Eva. Second row: Robert McGlynn, Wilbur Christopher, Sister M. Leonella, Sister M. Francine, Sister Mary Ellen, Sister M. Ursula, Sister Mary Edwardine, Robert DeBacker, Roy Thornton, Francis P. Weston, Melvin Nicholson, Sister Edelburg, Sister Olivia Marie, Sister M. Sylvia, Sister M. Geraldine, Sister M. Annella, Sister M. Amadeus, Sister M. Walter, Sister Myra James, Sister M. Consolata.

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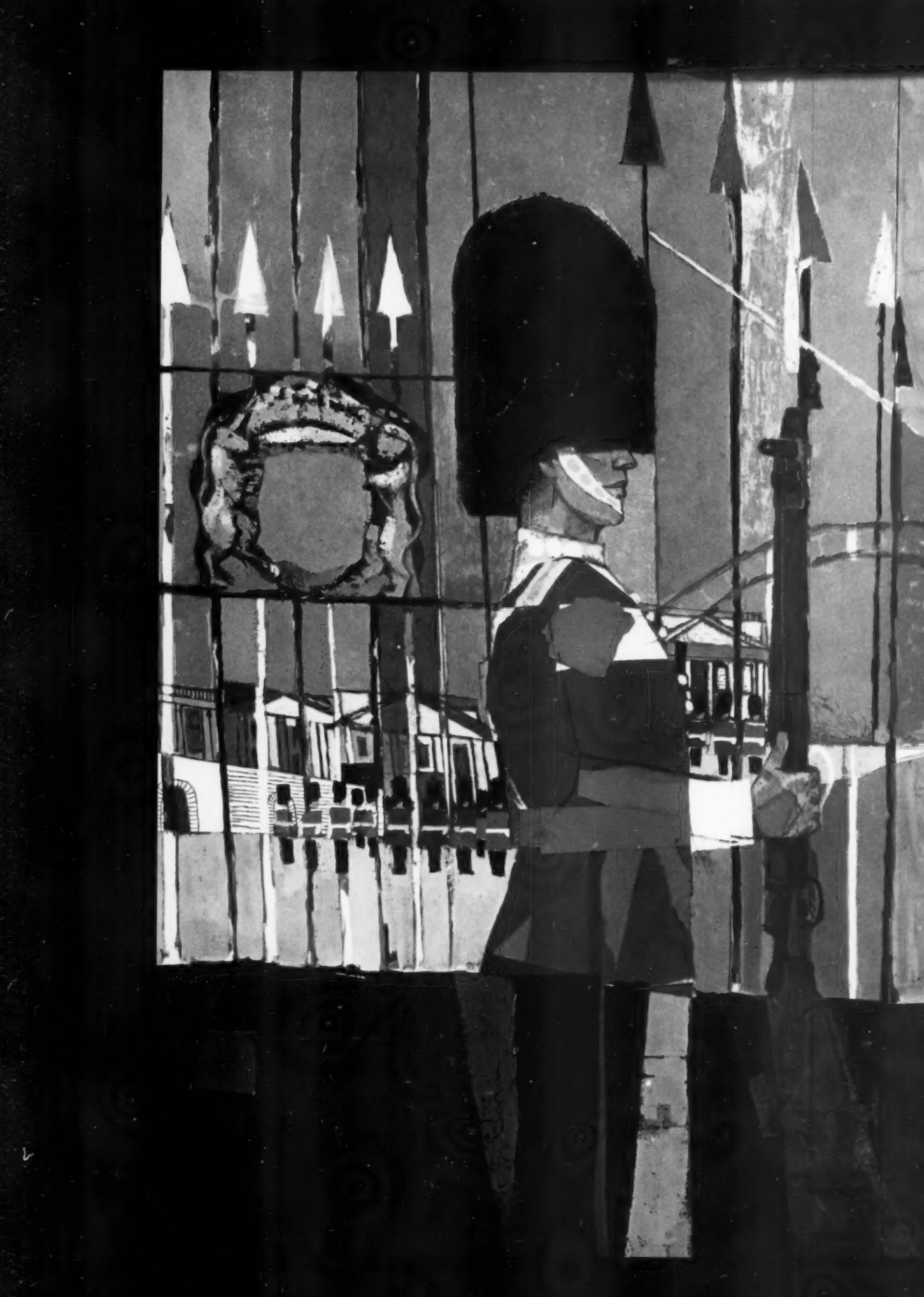

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Wisconsin Hospital Treats Tornado Victims, Offers Disaster Planning Advice

CHIPPEWA FALLS, WIS.—Thirty-five patients were admitted to St. Joseph's Hospital here last month following a series of tornadoes that struck four counties in the area. Another 19 persons were treated and allowed to leave the hospital. (See additional disaster news on page 58.)

Lights and power failed about five minutes before the first patient was admitted, the Sisters at the hospital reported.

"We were able to place two calls for doctors before our switchboard partially failed. Since we were able to accept calls, we asked callers to get help for us. The first person who called the hospital was asked to contact the police and ask them to notify our doctors. The police responded by going to each doctor's home, and in a few minutes a number of doctors were on hand.

"The second person who telephoned was asked to contact the fire department for emergency lighting to supplement our emergency lighting equipment. In short order we had good lighting in our emergency department and many people came in bringing battery lights and flashlights which were placed where most needed.

The Sisters offered the following suggestions to improve disaster planning in the future and to aid hospitals now making disaster plans:

1. If and when possible, emergency departments should be on the ground floor, as close as possible to the ambulance entrance.
2. Provision for a generator so that, in case of power failure, lights could be provided and elevators, food refrigerators, and blood bank refrigeration could be kept running.
3. More frequent "dry runs" of disaster plans so that the plan becomes familar even to new employes. In these "dry runs," conditions approximating actual disaster situations should be assumed as much as possible.
4. Simplification of disaster tag so it can be completed quickly.

Residencies Assigned at Washington University

ST. LOUIS. — Washington University students in hospital administration have been assigned to hospital residencies, as follows:

Arthurline Clingman to Veterans Administration Hospital, Houston, Tex.; James A. Faries Sr. to Good Samaritan Hospital, Vincennes, Ind.; Howard L. Hays to Iowa Methodist Hospital, Des Moines, Iowa; James Hepner to Jewish Hospital, St. Louis; Alva Hethcock to Baptist Memorial Hospital, Memphis, Tenn.

Charles Hudson to University of Mississippi Medical Center, Jackson; Charles Jarrett to Methodist Hospital, Indianapolis; Capt. Edgar Kilby to USAF Hospital, Lackland Air Force Base, Tex.; Glenn Lanier to Methodist Hospital, Houston, Tex.; Richard McFarland to Barnes Hospital, St. Louis; James Pears to Methodist Hospital, Houston, Tex.

Eugene Prentice to Orange Memorial Hospital, Orlando, Fla.; Fred Hatcher Smith to Barnes Hospital, St. Louis; Capt. Eual J. Smith to USAF Hospital, Maxwell Air Force Base, Montgomery, Ala.; Kurt P. Wendt to Madison General Hospital, Madison, Wis., and Wilton Zinn to Bishop Clarkson Memorial Hospital, Omaha, Neb.

Emory University Lists Residency Appointments

ATLANTA, GA.—Administrative residencies have been assigned to students of hospital administration in the school of business administration at Emory University as follows:

Carl A. Brunetto to Niagara Falls Memorial Hospital, Niagara Falls, N.Y.; Charles H. Burge to 3382d USAF Hospital, Maxwell Air Force Base, Montgomery, Ala.; Dean M. Crowder to Donald N. Sharp Memorial Community Hospital, San Diego, Calif.; James M. McCallum Jr. to Delaware Hospital, Wilmington; Melville L. Moore to University Hospital, Augusta, Ga., and George L. Percy to Veterans Administration Hospital, New York.

Students Appointed to Hospital Residencies by University of Minnesota

MINNEAPOLIS.—The following residency appointments have been announced for students in the course in hospital administration at the University of Minnesota:

Thomas Q. Bergfald to St. Luke's Hospital, Kansas City, Mo.; Arvid B. Brekke to Fairview Hospital, Minneapolis; Janet G. Brodahl to Bethesda Hospital, St. Paul; Thomas J. Campbell to Johns Hopkins Hospital, Baltimore; Glen R. Clark to Baylor University Hospitals, Dallas, Tex.; Richard A. Cranford to University of Kansas Medical Center, Kansas City, Kan.

Dr. Guillermo Fajardo-Ortiz to Mount Sinai Hospital, Minneapolis; Jack R. Fecteau to University of Minnesota Hospitals, Minneapolis; Gordon K. Flom to St. Luke's Hospital, Milwaukee; John S. Glass to Charles T. Miller Hospital, St. Paul; Roger E. Gurholt to Abbott Hospital, Minneapolis.

William J. Hartung to Highland Hospital, Rochester, N.Y.; Lawrence A. Hill to Rhode Island Hospital, Providence; Willis J. Hindman to Menorah Medical Center, Kansas City, Mo.; Keith E. Ingbritsen to University of Wisconsin Hospital, Madison; Victor M. Jaramillo to University of Texas Medical Branch Hospitals, Galveston; John J. Rockwell to Swedish Hospital, Minneapolis.

John P. Rugh to Syracuse Memorial Hospital, Syracuse, N.Y.; Raymond E. Seaver to St. Luke's Hospital, Duluth, Minn.; Cris A. Stang to Strong Memorial Hospital, Rochester, N.Y.; Paul A. Teslow to San Jose Hospital, San Jose, Calif.; Michael M. Walker to St. Luke's Hospital, Cleveland; Paul H. Ward Jr. to Stormont-Vail Hospital, Topeka, Kan.

University of Chicago Lists Student Residencies

CHICAGO.—Residency appointments for students in the class in hospital administration at the University of Chicago have been announced as follows:

David L. Allen to Alameda County Hospital, Oakland, Calif.; William L. Boyd to Memorial Hospital of Springfield, Springfield, Ill.; Thomas J. Broderick to Seaside Memorial Hospital, Long Beach, Calif.; Jerry L. Buckingham to Dallas City-County Hospital, Dallas; Gerald B. Cole to University of Indiana Hospitals, Indianapolis; Thomas E. Coull to Baptist Memorial Hospital, Memphis, Tenn.

Dean E. Leiser to Cleveland City Hospital, Cleveland; Lee Pridgen Jr. to military service; Jack C. Robinette to Ohio State University Hospitals, Columbus; James R. Shawver to White Memorial Hospital, Los Angeles; Alfred J. Sparkes Jr. to Strong Memorial Hospital, Rochester, N.Y., and Dr. Lauro Vivaldo-Fernandez to Gary Methodist Hospital, Gary, Ind.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Statler Hotel, Boston, Oct. 13-16.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Institutes: 26th Chicago, University of Chicago, Sept. 2-12; 9th Chicago Advanced, University of Chicago, Sept. 8-12.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Members Conferences: Region 11, Kansas City, Mo., Oct. 20-24; Region 10, Minneapolis, Oct. 27-31; Region 1, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21. Annual Meeting and Convocation, International Amphitheater and Orchestra Hall, Chicago, Aug. 16-18.

AMERICAN DIETETIC ASSOCIATION, Bellevue Stratford and Benjamin Franklin Hotels, Philadelphia, Oct. 21-24.

AMERICAN HOSPITAL ASSOCIATION, convention, Palmer House, International Amphitheater, Chicago, Aug. 18-21.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Boston, Oct. 26-29.

ARIZONA HOSPITAL ASSOCIATION, Westward-Ho Hotel, Phoenix, Nov 13, 14.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 28-31.

CALIFORNIA HOSPITAL ASSOCIATION, Biltmore and Miramar Hotels, Santa Barbara, Oct. 22-24.

COLORADO HOSPITAL ASSOCIATION, Cosmopolitan Hotel, Denver, Oct. 9, 10.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 21.

IDAHO HOSPITAL ASSOCIATION, Elks Temple, Boise, Oct. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Indiana Student Union Building, Indianapolis, Oct. 8, 9.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MINNESOTA HOSPITAL ASSOCIATION, Lowry Hotel, St. Paul, Nov. 7.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Heidelberg, Jackson, Oct. 23, 24.

MISSOURI HOSPITAL ASSOCIATION, President Hotel, Kansas City, Nov. 19-21.

MONTANA HOSPITAL ASSOCIATION, Havre, Sept. 15, 16.

NEBRASKA HOSPITAL ASSOCIATION, Sheraton-Fontenelle Hotel, Omaha, Oct. 23, 24.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

OREGON ASSOCIATION OF HOSPITALS, Gearhart Hotel, Gearhart, Oct. 13, 14.

VERMONT HOSPITAL ASSOCIATION, Hotel Vermont, Burlington, Oct. 8, 9.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

WASHINGTON STATE HOSPITAL ASSOCIATION, Winthrop Hotel, Tacoma, Oct. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

1959

ALABAMA HOSPITAL ASSOCIATION, Admiral Semmes Hotel, Mobile, Jan. 23, 24.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Sheraton-Palace Hotel, San Francisco, March 30-April 1.

ASSOCIATION OF WESTERN HOSPITALS, Hotel and Motel Utah, Salt Lake City, May 4-7.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, April 8-10.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, May 7, 8.

Preventive Care Urged at Middle Atlantic Assembly

(*Continued From Page* 124)

the American Hospital Association, explained the activities of the association in the field of health care of the aged, describing the recently formed Joint Council to Improve the Health Care of the Aged. The council will act as a clearinghouse for information concerning the ability of providers to meet the demands for health services, as well as the ability of people to pay for these services.

People must be urged to budget more of their disposable dollars for health care, he said, predicting that by 1980 one-third of hospital care would be provided to persons over 65.

OFFICERS

Dr. Ambrose P. Merrill Jr., superintendent of St. Barnabas Hospital, New York, was named president of the Middle Atlantic Hospital Assembly, succeeding John W. Kauffman, administrator of Princeton Hospital, Princeton, N.J. James C. Kirk, administrator of Pottsville Hospital, Pottsville, Pa., became vice president. Reelected as secretary and treasurer, respectively, were J. Harold Johnston, executive director of New Jersey Hospital Association, and John F. Worman, executive director of the Hospital Association of Pennsylvania.

The Hospital Association of New York State installed Theodore F. Childs, president of Lenox Hill Hospital, New York, as president. Elected first vice president was Carlton B. Shannon, administrator, House of the Good Samaritan Hospital, Watertown. Second vice president is Alex E. Norton, administrator of New Rochelle Hospital, New Rochelle. Dr. Bernard A. Watson, administrator of Clifton Springs Sanitarium & Clinic, Clifton Springs, was elected secretary, and Moir P. Tanner, administrator of Children's Hospital, Buffalo, was reelected treasurer.

Trustees are Lawrence J. Bradley, director, Genesee Hospital, Rochester, N.Y.; Martin R. Steinberg, director, Mount Sinai Hospital, New York; Howard R. Taylor, director, Niagara Falls Memorial Hospital, Niagara Falls, and Richard D. Vanderwarker, vice president and general manager of Memorial Center for Cancer and Allied Diseases, New York.

Ray K. Bolinger, administrator of Robert Packer Hospital, Sayre, Pa., was named first vice president and president-elect of the Hospital Association of Pennsylvania. Walter J. Rome, executive director, Children's Hospital of Pittsburgh, was installed as president.

Other officers, all reelected, are: second vice president, Mabel A. Barron, administrator, Ellwood City Hospital, Ellwood; executive director, John F. Worman of Harrisburg, and treasurer, Joseph W. Bishop, administrator, Hahnemann Hospital, Scranton.

Trustees are: Garrett P. Snyder, administrator of York Hospital, York, and James I. McGuire, administrator of Western Pennsylvania Hospital, Pittsburgh, for three years, and Norman W. Skillman, director of Chester County Hospital, West Chester, for two years. Mr. Skillman fills the unexpired term of Mr. Bolinger.

The New Jersey Hospital Association named David V. Carter, administrator of Fitkin Memorial Hospital, Neptune, as president-elect. Dr. A. L. Van Horn, medical director of Kate Macy Ladd Convalescent Home, Far Hills, was installed as president.

Vice president is Rt. Rev. Msgr. F.M.J. Thornton, St. Mark's Rectory, Sea Girt; reelected treasurer is Nelson O. Lindley, administrator of Somerset Hospital, Somerville. J. Harold Johnston continues as executive director. New trustees are: John W. Kauffman, administrator of Princeton Hospital, Princeton, and Cora E. Gould, administrator of New Jersey Orthopaedic Hospital Unit, Orange.

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Insurance Man Proposes That Hospitals, Doctors File Exact Rate Schedules

CHICAGO.—Filing of rate schedules by all hospitals and physicians was proposed here last month by Allen Dorfman of the Union Insurance Agency of Illinois, who spoke to members of the National Association of Insurance Commissioners.

Filing rate schedules, showing exact fee and cost structures, would eliminate "selective" charges by physicians and would protect against current hospital practice of "padding" miscellaneous charges for drugs, medicines, laboratory fees, and so on, Mr. Dorfman contended.

The solution to the current health insurance crisis, he said, may lie in the rate schedule proposition and in a pooling arrangement by which health insurance companies would band together to protect themselves from high risks and overcharging.

If the situation is not corrected, it may easily "lead down the path of socialized medicine," he said.

The growth of medical clinics set up by many groups, such as the Kaiser Foundation Health Plan, the Health Insurance Plan of Greater New York, and the International Harvester Company, is not "something coming tomorrow," Mr. Dorfman said. "It is with us today, and it really does not matter whether they are being successful or not. Their very existence indicates that many people are thinking in the direction of socialized medicine as the only answer to medical care for everyone at a nonprohibitive cost."

A.M.A. and A.H.A. Report 1958 Expenditures for Congressional Lobbying

WASHINGTON, D.C.—The American Medical Association, followed by the American Nurses' Association and the American Hospital Association, led the list among health groups in expenditures for congressional lobbying during the first quarter of 1958, it was reported in the May 20 *Congressional Record*.

Disbursements were as follows: American Medical Association, $13,504.26; American Nurses' Association, $11,395.36; American Hospital Association, $10,607.45. Others were: American Cancer Society, $7,170.76; American Optometric Association, $4,645.15; Association of American Medical Colleges, $1,666.68; Association of American Physicians and Surgeons, $1500; Michigan Hospital Service, $1,271.92, and Arthritis and Rheumatism Foundation, $1,155.74.

Late reports for the fourth quarter of 1957 were as follows: American Hospital Association, $11,015.83; American Cancer Society, $7,000.25; American Nurses' Association, $4,639.67, and United Cerebral Palsy, $1,250.09.

Philadelphia Group Elects

PHILADELPHIA.—George A. Hay, administrator of the Hospital of the Woman's Medical College of Pennsylvania, has been elected chairman of the advisory board of the Hospital Council of Philadelphia for 1958-59. He succeeds Dr. Howard W. Baker, administrator of Temple University Hospital, who served as chairman for three years.

V.A. Revises Nurse Grades

WASHINGTON, D.C.—A revision in standards for nursing grades and salaries for its nurses was announced last month by the Veterans Administration. The revision will improve appointment and promotion opportunities for nurses in the V.A., making it possible for them to reach the associate grade and full grade in less time than previously, a V.A. announcement said.

F. S. Walters Jr. Named Texas President-Elect

DALLAS, TEX.—F. S. Walters Jr., administrator of Northwest Texas Hospital, Amarillo, was named president-elect of the Texas Hospital Association at the 29th annual convention held here recently. W. P. Earngey Jr., administrator of Harris Hospital, Fort Worth, was installed as president.

Other officers are: vice president, Albert H. Scheidt, administrator of Dallas County Hospital District, and treasurer, F. R. Higginbotham, administrator of Baptist Memorial Hospital, San Antonio.

Trustees are: Sister Mary Vincent, administrator of St. Joseph's Hospital, Fort Worth, and C. H. McCrary, administrator of Medical and Surgical Clinic Hospital, Tyler, three-year terms; Mrs. Luella H. Huffman, administrator of Upton County Hospitals, McCamey and Rankin, and Guy H. Dalrymple, administrator of Baptist Hospital of Southeast Texas, Beaumont, two-year terms, and W. E. Arnold, administrator of Scott and White Memorial Hospital, Temple, one-year term.

A.H.A., Other Groups Play Host to WHO Delegates

CHICAGO.—The American Hospital Association and the Joint Commission on Accreditation of Hospitals joined with three other health groups here last month to play hosts to representatives of 20 nations en route home from the 10th anniversary assembly of the World Health Organization held recently in Minneapolis.

A program of receptions, lectures, medical motion pictures, tours of medical installations, and sightseeing was arranged for the medical men by the five groups, which also included the American Medical Association, American College of Surgeons, and the American Dental Association. All the organizations have headquarters in Chicago.

NOTICE TO READERS

Before you send to the binders your copies of the 1958 issues of The Modern Hospital, you will want a copy of the index to each volume. The index to Volume 90 (January to June) may be obtained by addressing a postcard or letter requesting a copy to The Editor, The Modern Hospital, 919 North Michigan Avenue, Chicago 11, Ill. There is no charge. Those persons who have previously written for the index to Volume 89 (July to December 1957) will be sent the latest index without further correspondence.

ABOUT PEOPLE

(*Continued From Page 78*)

Marvin J. Bostin

Marvin J. Bostin has been appointed administrative assistant at Long Island Jewish Hospital, New Hyde Park, N.Y. Mr. Bostin was graduated from Columbia University this June with a master's degree in hospital administration. He served as administrative resident at the Long Island hospital while attending the university. Mr. Bostin also is a pharmacy graduate of the University of Toronto.

Michael J. Wood, director of hospital and clinics, University of Florida Health Center, Gainesville, has been appointed executive director of Duval Medical Center, Jacksonville, Fla., effective July 1. Mr. Wood succeeds **Dr. Joel J. White,** who has resigned.

Vernon L. Ballard has been named administrator of Portsmouth Hospital, Portsmouth, N.H. Formerly, he was administrator of Claremont General Hospital, Claremont, N.H.

Fred F. Ellison

Fred F. Ellison, administrator of Tri-City Hospital, Leaksville, N.C., has been appointed administrator of Oconee Memorial Hospital, Seneca, S.C., succeeding **Milton C. Snipes,** who has taken a similar position at Chesterfield County Hospital, Cheraw, S.C. Mr. Ellison is a graduate of Georgia Institute of Technology and is a member of the American College of Hospital Administrators.

Dr. Robert F. Ingram, assistant director (medical) of Royal Victoria Hospital, Montreal, Que., has been appointed executive director of Montreal Children's Hospital, succeeding **Dr. John E. de Belle,** who is retiring for reasons of health. Dr. Ingram has held the positions of administrative resident and administrative assistant at Royal Victoria Hospital. He did postgraduate work in hospital administration at the University of Toronto.

William H. Thrasher, administrator of Athens General Hospital, Athens, Ga., has been named administrator of a proposed new 200 bed hospital to be constructed in DeKalb County, Georgia. His appointment is effective August 1. Mr. Thrasher formerly was director of John D. Archbold Memorial Hospital, Thomasville, Ga., and

administrative resident at St. Luke's Hospital, Milwaukee. He is a graduate of the University of Minnesota's hospital administration program.

Manson Turner, administrator of Marion County Memorial Hospital, Marion S.C., has been appointed administrator of Ocean View Memorial Hospital, Myrtle Beach, S.C. The hospital is scheduled to be opened this summer. Mr. Turner spent 20 years in the navy in hospital work.

Theodore Frazier has been appointed administrator of Wheatley-Provident Hospital, Kansas City, Mo., succeeding **James P. Neal,** whose appointment as administrator of Community Hospital of Evanston, Ill., was announced in the June issue of The Modern Hospital. Mr. Frazier received his degree in hospital administration from the University of Iowa.

Robert J. Myers has been named administrator of Riverton Hospital, Seattle, which is being converted to a general hospital from a tuberculosis sanitarium. Mr. Myers, a graduate of the University of California course in hospital administration, served his administrative residency at Doctors Hospital, Seattle.

Pierina Egan, administrator of Nassau County General Hospital, Fernandina Beach, Fla., since it opened nearly 16 years ago, has resigned. Mrs. Egan will be succeeded by **John Page,** who was appointed acting superintendent.

Thomas B. Reed has been appointed administrator of the new South Baldwin Memorial Hospital, Foley, Ala. Mr. Reed has been administrative resident at Louisville Medical Center, Louisville, Ky., for the last year, completing requirements for his master's degree in hospital administration, which he received from Northwestern University.

Department Heads


W. M. Moore

W. M. Moore has been appointed controller of Children's Mercy Hospital, Kansas City, Mo. Mr. Moore, who formerly was associated with Children's Hospital in San Francisco, received his master's degree in hospital administration from Northwestern University. He is a business administration graduate of the University of Missouri.

William Lau and **Mary Peterson** have been named pharmacist and assistant chief pharmacist, respectively, at Louis A. Weiss Memorial Hospital, Chicago. Mr. Lau is a graduate of the school of pharmacy at North

Dakota State College and previously worked in Milwaukee. Miss Peterson, a graduate of the University of Illinois School of Pharmacy, has had several years of hospital pharmacy experience in Chicago. It was also announced that **Lucito Gambo** has been appointed assistant medical records librarian at the hospital. Mrs. Gambo is a graduate of the University of Colorado and the University of Denver.

Barbara D. Mills has been appointed director of building services, Roosevelt Hospital, New York. Most recently, Mrs. Mills was director of housekeeping at Allegheny General Hospital, Pittsburgh, and formerly held a similar post at St. Luke's Hospital, Chicago.

Miscellaneous

Capt. J. E. Stone, director of the division of hospital facilities of King Edward's Hospital Fund for London, England, resigned recently after serving in the hospital field for 38 years. He held positions in several hospitals before joining the staff of the fund in 1939 as consultant on hospital finance. He was appointed director of the division in 1948. Capt. Stone is the author of "Hospital Organisation and Management" and "Hospital Accounts and Financial Management." He was the first honorary secretary and treasurer of the International Hospital Federation; he is an honorary fellow of the American College of Hospital Administrators and an honorary member of the American Hospital Association. **W. E. Hall,** assistant director of the division of hospital facilities, will succeed Capt. Stone.

Tasker K. Robinette

Tasker K. Robinette, formerly administrative officer in the USAF Hospital, Fairchild Air Force Base, Wash., has been named director of hospital services, Consultant Associates, Inc., Long Branch, N.J. Mr. Robinette is a graduate of the Washington University program in hospital administration and served his administrative residency at Monmouth Memorial Hospital, Long Branch, N.J.

Dr. Leroy E. Burney, surgeon general of the United States, was elected president of the World Health Organization at the 11th annual assembly of the United Nations world health group held in Minneapolis recently.

Joseph Sherber

Joseph Sherber has been appointed to the staff of the president of the State University of New York Downstate Medical Center, Brooklyn, to assist in planning and development. Mr. Sherber formerly was administrative assistant at New York Hospital, New York. He is a graduate of the hospital administration course at Columbia University.

Charles G. Skinner, assistant director in charge of the institute program of the American College of Hospital Administrators, has resigned to accept a position at the University of Michigan. He will become research associate with the study of hospital and medical economics in Michigan. Mr. Skinner was assistant director of the University of Minnesota Hospitals before he joined the staff of the college in 1955.

Eleanor C. Lambertsen, assistant professor of nursing at Teachers College, Columbia University, has been appointed assistant secretary of the American Hospital Association's council on professional practice and secretary of the council's committee on nursing. Miss Lambertsen will serve on a part-time basis until October 1, when she will become a full-time staff member. At the same time it was

announced that **Elton T. TeKolste** and **Jack W. Owen,** staff representatives of the A.H.A.'s council on administrative practice, have been appointed assistant secretaries of the council.

Dr. John C. Cutler, deputy chief of the Public Health Service Bureau of Medical Services, has been appointed assistant surgeon general, assigned to work in the office of Surgeon General Burney. It was also announced that **M. Allen Pond,** on assignment to Secretary Folsom for the past several years, has been named an assistant surgeon general.

Deaths

Sister Mary Tryphosa, administrator of St. Joseph's Hospital for Chest Diseases, New York, died recently at the age of 78. She had been administrator and sister superior at the hospital since 1954, having previously held the same posts there in the Thirties. She also had been administrator of St. Francis Hospital, Cincinnati; St. Joseph's Hospital, Quincy, Ill.; St. Anthony's Hospital, Columbus, Ohio, and St. Anthony's Hospital, Woodhaven, N.Y.

Anne L. Lachner, former director of public relations for the Blue Cross and Blue Shield plans of Iowa, died recently of a heart ailment at the age of 70. Mrs. Lachner helped to organize the plan and later directed its Tri-Cities office before becoming public relations director. She was a former second vice president of the Iowa Hospital Association and was active in many Iowa and Des Moines health groups.

Dr. Gale H. Walker, superintendent of Polk State School, Polk, Pa., died recently of a heart attack. He was 52. He was a fellow of the American Psychiatric Association and a fellow and past president of the American Association of Mental Deficiency.

Dr. Guy H. McKinstry, director and president of Hillsview Clinic, Inc., Washington, Pa., died recently at the age of 74. For many years he was a member of the executive committee of the Pennsylvania Blue Shield Plan.

CORRECTION

It was incorrectly reported in the May issue of The Modern Hospital that **Joseph H. Powell,** newly appointed assistant administrator of Baptist Memorial Hospital, Memphis, Tenn., received his master's degree in hospital administration from the University of Tennessee. Mr. Powell completed his undergraduate work at the University of Tennessee and holds a master's degree in administration from the University of Minnesota.

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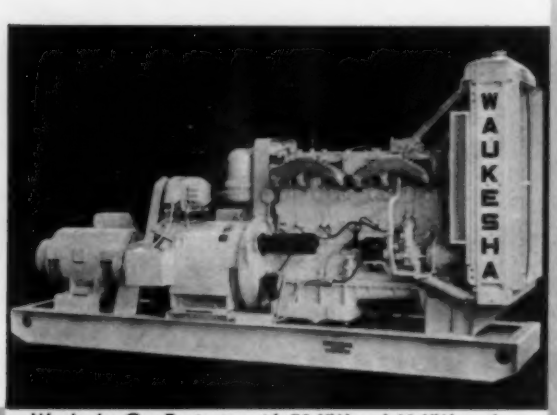

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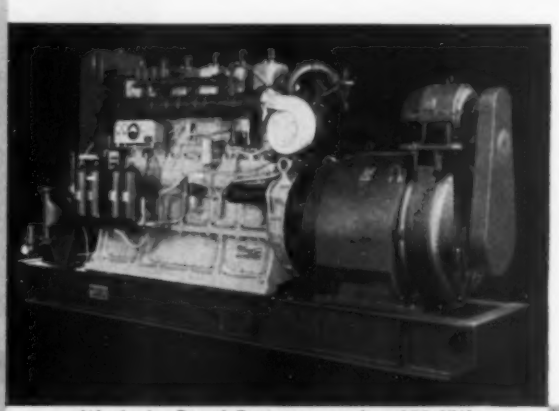

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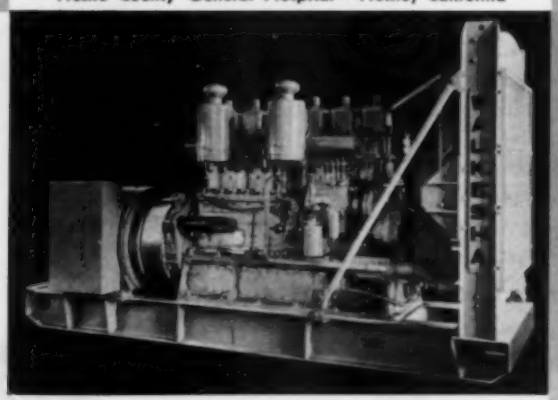

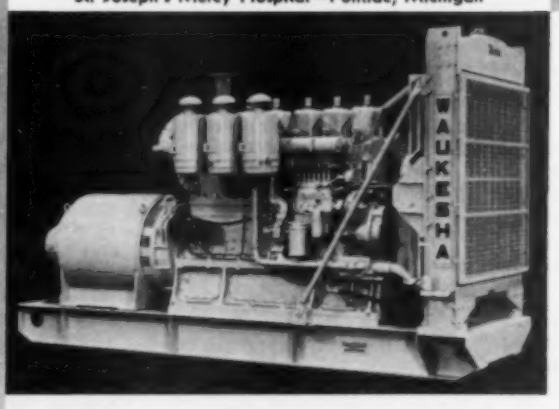

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ANESTHETISTS—Certified registered nurse; two; male; desire opportunity to take charge of anesthesia department on free lance basis in small community hospital; excellent references. Apply MW 31, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHESIOLOGIST—Board Certified; 12 years experience; last 5 years chief of approved department in large general hospital; prefer organize or head department; teaching experience; best recommendations. Reply MW 22, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

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WOODWARD—Continued

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RADIOLOGIST—2 years, assistant radiologist, university hospital; 15 years, chief, radiology, 250-bed, voluntary, general hospital; seeks chief or associate chief, larger hospital; prefer with isotopes; any locality; Diplomate FACR.

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PATHOLOGIST—Diplomate; 4 years, associate pathologist, teaching hospital and on faculty of medical school as associate professor; 5 years, director department, 300-bed general hospital.

RADIOLOGIST—Training in radiology, teaching hospital; 3 years, private and hospital practice; Diplomate.

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ADMINISTRATOR—Age 42; successful experience, 12 years 150-bed hospital, Virginia.

ADMINISTRATOR—R.N.; 15 years executive experience; presently administrator 60-bed Ohio hospital.

(Continued on page 148)

INTERSTATE—*Continued*

ASSISTANT ADMINSTRATOR—M.B.A. Degree, 1958; previously office manager, southern institution, administrative residency, 200-bed hospital.

DIRECTOR, NURSING SERVICE—M.A. Degree, western university, 6 years supervisory experience, Arkansas and Oklahoma hospitals; 3 years director, nursing service, 250-bed mid-western hospital.

EXECUTIVE HOUSEKEEPER—College education; course in institutional management; 6 years experience, southern and Florida hospital.

EXECUTIVE HOUSEKEEPER — Age: 41 years; 2 years assistant, new 275-bed mid-western hospital; 3 years director, housekeeping services.

POSITIONS OPEN

ADMINISTRATOR—Assistant; leading to administrator's position; thirty-five bed, progressive general hospital; M.S.H.A. or equivalent experience necessary; salary open. Address replies to: Secretary to Mr. M. Hughs, President, c/o Capitol Hospital, 1971 W. Capitol Drive, Milwaukee, Wisconsin.

ANESTHESIOLOGIST — Wanted to work either "free lance" in city with two hospitals, or work for one hospital in charge of department. Reply MO 234, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; New 50-bed hospital; excellent working conditions and personnel policies. Contact Administrator, Dearborn County Hospital, P. O. Box 72, Lawrenceburg, Indiana.

ANESTHETISTS—Nurse; two; starting salary $425.00 per month. Write Administrator, St. Joseph Mercy Hospital, Ann Arbor, Michigan.

ANESTHETIST—Nurse; opening in obstetric department; 11:00 p.m. to 7:30 a.m.; liberal employee benefit program includes vacation, sick pay, and holidays. Write Personnel Department, St. Joseph Mercy Hospital, 900 Woodward Avenue, Pontiac, Michigan.

ANESTHETIST—Nurse; excellent working conditions, beginning salary $400.00 with extra pay for call duty; four weeks' vacation annually; department under direction of M.D. anesthesiologist. Apply Personnel Dept., Mt. Sinai Hospital, Minneapolis 4, Minn.

ANESTHETIST—Nurse; for 215-bed general hospital; starting salary $450 a month with vacation, sick leave and retirement benefits. Apply Murray A. Hintz, Administrator, Bernalillo County-Indian Hospital, Albuquerque, New Mexico.

ANESTHETISTS—Wanted several nurse anesthetists for enlarged anesthesia department in a 250-bed general hospital located in a resort town eight miles from famous Wrightsville Beach, North Carolina. Write James Walker Memorial Hospital, Wilmington, North Carolina.

ANESTHETIST — Registered nurse; wanted. Write or call Dr. L. G. Merrill, St. Benedict's Hospital, Ogden, Utah, for details.

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POSITIONS OPEN

ANESTHETIST—Nurse: $400-$600 per month; excellent medical staff; 200-bed hospital; fringe benefits, health, life, retirement insurance; paid vacation-sick leave; hospital cafeteria, nurses' home accommodations. Contact E. J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETIST—Nurse R.N.A.; for information write, Administrator, North Big Horn Hospital, Lovell, Wyoming.

DIETITIAN—A.D.A. or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

DIETITIAN—Opening in 400-bed hospital which is adding 120-bed rehabilitation unit; excellent opportunity in therapeutic or administrative work for A.D.A. registered person; salary commensurate with training and experience; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines, Iowa.

DIETITIAN—Teaching and therapeutic; must be A.D.A. member; new department and equipment; hospital is expanding to 250-beds; excellent personnel policies including 3 weeks vacation; salary in accordance with experience. Apply Personnel Director, Bethany Hospital, 51 North 12 Street, Kansas City, Kansas.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A. or equal, full charge of department in 55-bed general hospital; modern kitchen, excellent conditions, salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

DIETITIAN—Chief; A.D.A.; to be in charge of food service for 500-bed general hospital. Apply Harriette S. Oeftiger, Personnel Director, Wilson Memorial Hospital, Johnson City, New York.

STAFF DIETITIANS—One teaching; one therapeutic; A.D.A. members, hospital recently expanded to 450-beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIAN—Chief; for 500-bed teaching hospital; staff of 100 employees; pleasant college community; liberal personnel policies. Reply Personnel Director, University of Virginia, Charlottesville, Virginia.

DIETITIAN—Assistant; excellent opportunity to gain administrative and therapeutic experience in 170-bed general hospital; JCAH approved; 40 hour week; salary open. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

DIETITIANS—ADA registered; positions in a system of 10 new general hospitals with large out-patient department; educational material and visual aids being developed for the instruction of patients and families; modern dietary department, centralized trayveyor; employee and visitor cafeteria; we are still developing nutrition and dietary instructions; hospitals in West Virginia and Kentucky; salary ranges begin at $4860 and $5340 per annum, depending on your qualifications; annual increments; 40 hour week, 7 paid holidays, 4 weeks paid vacation; employee health program; social security plus retirement plan. Write Miners Memorial Hospital Association, Box #61, Williamson, West Virginia.

DIRECTOR OF NURSING SERVICE—Expanding 300-bed West Coast hospital, metropolitan location; salary open; desire candidate with 2 years demonstrated progressive administrative experience plus MA in Nursing Administration, or 6 years comparable experience. Write MO 218, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ASSISTANT DIRECTOR — Occupational therapy, registered; modern tuberculosis hospital, with affiliation program; five day week, 40 hour, paid vacations, 7 holidays, sick leave, social security; excellent opportunity for progressive administrator. Resume to Director, Occupational Therapy, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

ASSISTANT DIRECTOR OF NURSING—Service and education; large midwestern hospital in pleasant suburban area; furnished apartment available; near excellent shopping facilities and transportation; paid vacation, sick leave and retirement plan. Send resume of experience and training to MO 220, The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Illinois.

ASSOCIATE DIRECTOR, NURSING EDUCATION—200 student university affiliated school using clinical facilities of 400-bed JCAH fully approved hospital which includes 115-bed pediatric unit; desire person capable of developing judgment, nursing skills and problem-meeting ability of a select group of girls recruited once each year; experienced masters nursing education degree candidate preferred, will accept B.S. degree candidate with demonstrated successful experience; salary open, 40 hour work week, 4 weeks vacation, sick leave benefits; position available August 1. Apply to Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

ASSISTANT DIRECTOR, SCHOOL OF NURSING—Assist with the administration of NLN fully accredited diploma program with university affiliation for basic sciences; 160 students; academic preparation and successful experience required; position offers opportunity for leadership and initiative; excellent personnel policies and pleasant working conditions; comfortable furnished apartment available if desired; ideal summer climate. Write Director, School of Nursing, St. Luke's Hospital, Duluth, Minnesota.

ASSISTANT DIRECTOR OF NURSING SERVICE—Position requires qualifications of BSc in Nursing with experience in administration. Applications to be made to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

DIRECTOR OF HOUSEKEEPING SERVICES To assume entire responsibility for housekeeping operation, linen service and sewing rooms; new, modern hospital located on Chicago's north shore; presently a 200-bed hospital with plans for expansion; excellent starting salary; many liberal benefits including one month's vacation and free Blue Cross hospitalization insurance. Apply MO 232, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

(Continued facing page 149)

INSTRUCTOR—Clinical; needed for obstetrical nursing; position open July; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in Nursing Education; salary open; 40-hour work week; 20 working days vacation; sick benefits. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTOR—Psychiatric nursing; progressive State Hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $4140 to $8100 plus self-maintenance, liberal sick time, holidays, paid vacation. Write Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

INSTRUCTORS—Faculty appointments open for obstetric clinical instructor and for pediatric clinical instructor for programs of teaching concurrent with experience; NLN fully accredited school, 125 students; modern 300-bed hospital with adjacent school facility, located in community having three colleges; prefer degree in nursing; will consider supplementary training and experience in the field. Apply to Director of Nursing, Bronson Methodist Hospital, Kalamazoo, Mich.

INSTRUCTORS—Applications for faculty positions open July 1 are being considered for surgical instructor, for pharmacology instructor, and for assistant nursing arts instructor; NLN fully accredited school, 125 students; modern 300-bed hospital wtih adjacent school facility, located in community having three colleges; prefer degree in nursing education; will consider degree in nursing with supplementary experience. Apply to Director of Nursing, Bronson Methodist Hospital, Kalamazoo, Mich.

INSTRUCTORS—Clinical; medicine and surgery, and obstetrics; to increase faculty; excellent personnel policies with educational advantages; 40 hour week, salary open; new hospital and school facilities; 35 miles from central Philadelphia; prerequisite: B.S. degree in nursing education; position open. Apply Director of Nursing, Pottstown (Pa.) Hospital.

MISCELLANEOUS INSTRUCTORS—Medical—Surgical—Obstetrical—Operating Room; should have a B.S. degree in Nursing Education and a minimum of two years experience in two of the following positions: Instructor, Assistant Instructor, Head Nurse; 366-bed private general hospital with expansion program to be completed soon; 150 student School of Nursing with three year diploma course. Contact Personnel Department, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

NURSING INSTRUCTORS—Medical, Surgical and Nursing Arts; liberal salary; many benefits; B.S. degree in Nursing Education plus experience; 200-bed suburban hospital. Send resume or call Miss Dean, East Orange General Hospital, 300 Central Avenue, East Orange, New Jersey; ORange 2-8400.

CONSULTING MEDICAL RECORD LIBRARIAN AND MEDICAL RECORD TECHNICIAN—New 40-bed hospital and neighboring hospital wish to engage qualified medical record librarian; salary open; location northwest Wisconsin; 40 hour work week; organizational ability required. Apply Mo 230, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Registered or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

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POSITIONS OPEN

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Registered medical record; to take charge of record room; 360-bed, fully accredited hospital; salary open. Write Superintendent, Washington Hospital, Washington, Pennsylvania.

MISCELLANEOUS—200-bed general hospital, located in New Jersey has the following openings: Director of Nursing, Central Supply Supervisor, Director of Volunteers, Medical Social Worker, Medical Record Librarian, Physical Therapist, Dietitian, A.D.A. General Duty Nurses, eligible for New Jersey License, Operating Room Nurses. Apply MO 231, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS — Director of Education, Graduate Nurses, Dietitian; 2,000-bed Psychiatric State Hospital; favorable employee benefits and environment with opportunity. Write Gay D. Barton, Personnel Officer, State Hospital No. 3, Nevada, Missouri.

NURSING MISCELLANEOUS — Portland, Oregon, is a fine place to live; The University of Oregon Medical School Hospital is a fine place to work; Staff positions open in Medical, Surgical, Pediatric, O.R. and Isolation units; beginning salary $310.00 per month with six months' experience; liberal personnel policies; opportunities for taking courses leading to baccalaureate or masters degrees at nursing school on campus; reduced tuition rates for employees. Write for information to Director of Nursing, University of Oregon Medical School Hospital, Portland 1, Oregon.

NURSES—Professional; For Arizona; new 75-bed non-profit, community hospital, (fully refrigerated) opening in May; supervisors, head nurses needed for all shifts; starting salary $325.00 to $360.00 per month, 40 hour week, liberal sick leave, vacations, uniforms laundered. Address all inquiries c/o Administrator, Yuma District Hospital, P.O. Box 222, Yuma, Arizona.

NURSES. Operating room—137-bed expanding hospital in Berkeley, California, one mile from the University of California and across the bay from San Francisco; $320 plus $10 differential for one year's experience or supplementary work, 40-hour week, rotate day and P.M. shift, overtime, on-call pay; liberal personnel policies, annual vacation, sick leave, hospital group insurance. Please contact Mrs. Marion Foster, Director of Nursing, Alta Bates Community Hospital, Berkeley, Cal.

NURSES—Registered staff; immediate openings; start $337 per month; differential pay, 5 day week; 11 paid holidays; sick leave, group insurance; good working conditions; large general hospital. Contact Personnel Director, 732 E. Main Street, Stockton 2, Cal.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Registered; 213-bed general hospital; liberal salary and personnel policies; all shifts and services available; progressive, hospitable city, 90 miles from seashore; ideal climate, adjacent military bases. Contact Director Nurses, Phoebe Putney Memorial Hospital, Albany, Georgia.

NURSES — Registered; immediate openings; starting salary $280 month with opportunity for advancement; room, board and laundry; annual vacation, liberal sick leave, 40 hour week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSES—Registered; psychiatric hospital in metropolitan area; liberal personnel policies, 40 hour week, attractive residence; positions available on all shifts; differential salary for evening and night service. Inquire Director of Nurses, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

NURSES—Registered; female, with New York State licenses. Apply to Mr. John C. Doyle, Assistant Administrator, 9 East 91st Street Hospital, New York 28, New York.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSE—Registered; operating room; good salary; excellent working conditions and personnel policies. Contact J. Milton Ramsour, Administrator, Memorial Hospital, Pecos, Texas.

NURSE—Registered; floor supervisor; 35-bed general hospital; starting salary $330 per month; differential for night duty; excellent working conditions and personnel policies. Contact J. Milton Ramsour, Administrator, Memorial Hospital, Pecos, Texas.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; 170-bed general hospital, located in "The Fruitbowl of the Nation," ideal climate, convenient recreational facilities year round; starting base salary $300.00 per month. Apply Director of Nurses, Yakima Valley Memorial Hospital, Yakima, Washington.

NURSES—General duty; for 55-bed hospital; salary $220 per month plus maintenance; annual increases up to 3 years; traveling expenses refunded on completion of 12 month service. Please apply Director of Nursing, The Lady Minto Hospital, Chapleau, Ontario.

NURSE—General duty; immediately; straight rotating 8 hour shift. For further information please apply to Sister Superior, Hospital Notre-Dame, Val Marie, Saskatchewan.

PERSONNEL MANAGER—300-bed hospital; to organize and direct program. Apply Sharon General Hospital, Sharon, Pennsylvania.

(Continued on page 150)

PHYSICAL THERAPIST—Male or female; excellent opportunity to head up new department in recently expanded 150-bed general hospital; retirement plan, social security, liberal fringe benefits; salary open. Write Administrator, Alpena General Hospital, Alpena, Michigan.

RADIOLOGIST—Full time associate; certified; 486-bed general hospital; very active department and fully equipped for x-ray work; opportunity for qualified radiologist; excellent remuneration; state training, experience, availability, marital status, etc. Apply to Director, The Royal Columbian Hospital, New Westminster, British Columbia, Canada.

SUPERVISOR-INSTRUCTOR—Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 96 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Administrative for obstetrical department; supervisor for evening shift; 365-bed general hospital; Bachelor's degree in Nursing Service Administration, but will consider others, and 5 years experience in supervision required; NLN accredited school of nursing; progressive personnel policies include 20 working days vacation; salary open; educational and cultural advantages of Chicago. Send resume of experience and training to Director of Nursing Service, St. Anne's Hospital, 4950 West Thomas St., Chicago 51, Ill.

SUPERVISOR — Medical-Surgical; a capable nurse supervisor for 239-bed medical-surgical unit of 400-bed hospital having 200 student School of Nursing; prefer person with degree in Nursing Service Administration, but will consider others; 5 day, 40 hour work week; liberal vacation and other benefits. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

SUPERVISORS—Ward; for surgical, medical and obstetrical wards. For further information please apply The Administrator, Yarmouth Hospital Commission, 60 Vancouver Street, Yarmouth, Nova Scotia.

TECHNICIAN—Laboratory; for 41-bed, modern hospital, located between Phoenix and Tucson, Arizona; salary $400-$450; 40 hour week; overtime pay; 25% of all monthly call work; 2 to 3 weeks vacation with pay; 12 days a year sick leave, accumulative to 36 days; 7 paid holidays a year; social security; group hospital insurance available. Reply to Hoemako Hospital, Box 1837, Casa Grande, Arizona.

TECHNICIAN—Laboratory; 236-bed general hospital 20 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

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POSITIONS OPEN

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ADMINISTRATORS—(a) Administrator, new hospital, 160-beds in TB wing, 161 in general hospital; interesting opportunity outside US; degree, 8 years experience in hospital administration or equivalency required. (b) Commissioner of hospitals; direct 2 hospitals, combined capacity 800-beds; MD degree or degree in hospital, business or public administration and extensive experience required; university city, midwest. (c) Lay administrator, qualified assume duties of chief staff officer, new central office, medical organization. (d) Administrator; 300-bed general hospital; university city, Pacific Coast. (e) Assistant; 300-bed general hospital; suburb, large city, Pennsylvania. MH7-1

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) Two; 260-bed general hospital; town 60,000, New England, 2 hours drive from New York City; $525. (b) Small general hospital, Hawaii; $450-$500. MH7-2

CONSULTANTS—(a) Nurse consultant; liaison with hospitals, professional organizations; important industrial company, east; to $7500. MH7-3

DIETITIANS—(a) Chief, 200-bed hospital serving industrial group; Mid-Atlantic state, $7080. (b) Chief; new 350-bed hospital; Pacific Islands; $5200. MH7-4

DIRECTORS OF NURSING—(a) Director, new school of nursing, collegiate program; university town, midwest; to $10,000. (b) Associate director; 800-bed teaching hospital; large city, midwest. (c) Assistant director; 450-bed hospital, outside US; attractive offer. MH7-5

EXECUTIVE PERSONNEL—(a) Comptroller; 400-bed hospital; east; $8000. (b) Purchasing director; 350-bed hospital university town, Michigan $7000. (c) Food service director; 500-bed teaching hospital; $10,000. MH7-6

FACULTY POSTS—(a) Instructors pediatrics, psychiatry; junior college; Florida. (b) Educational director; 325-bed hospital; California; $6000-$7200. (c) Chairman, nursing research department important eastern university; doctorate preferred; $660; 10-months. MH7-7

(Continued on page 152)

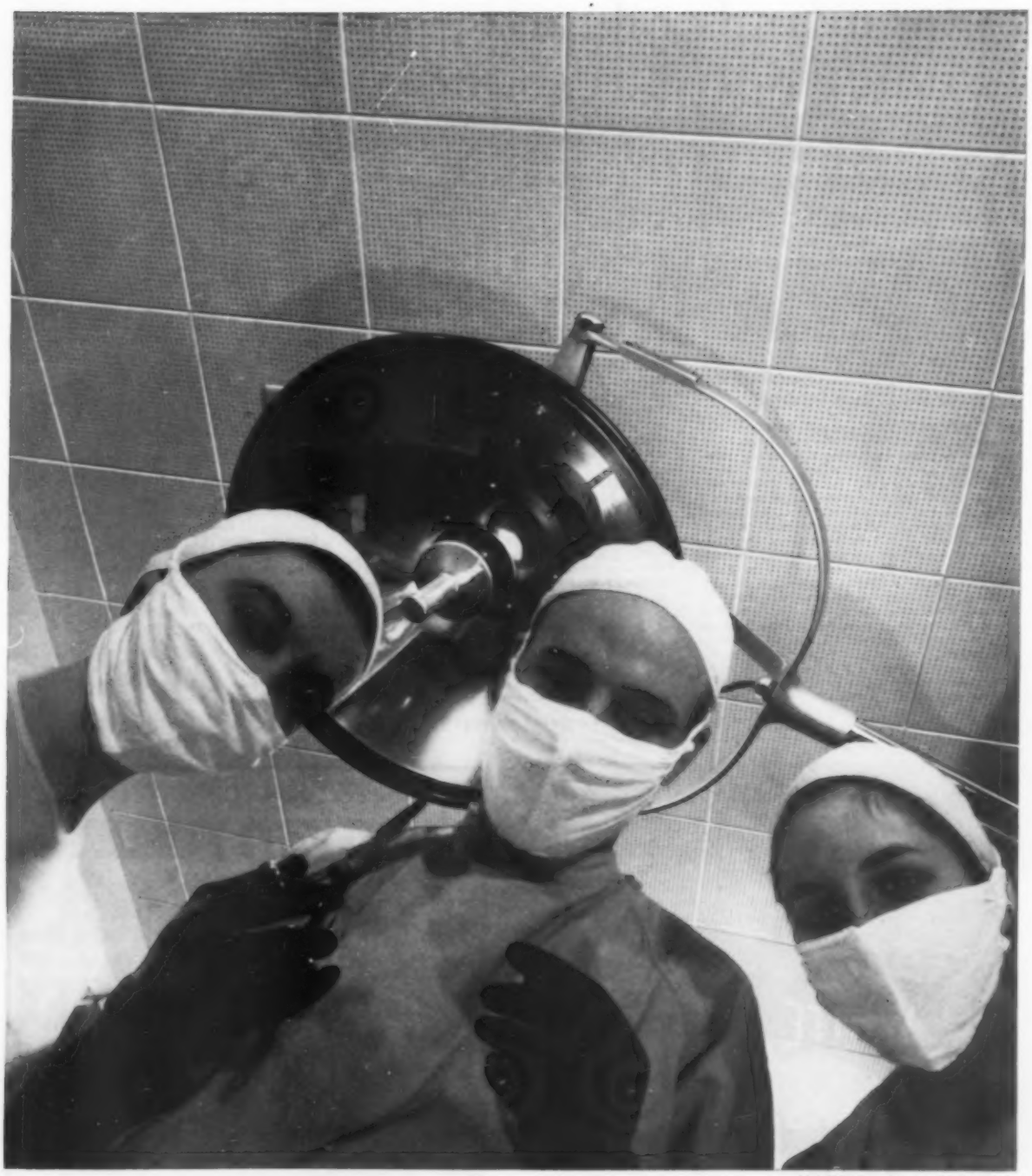
MEDICAL BUREAU—Continued

LABORATORY PERSONNEL—(a) Chief laboratory technician, 7-man clinic and affiliated hospital; town of 25,000 near Sun Valley; $450-$500. (b) Chief pharmacist; new department currently under construction; 450-bed hospital; outside US. (c) Chief physical therapist; new 200-bed hospital; $6400 and $5300 respectively; south. (d) Chief technician and assistant; laboratory of two Board internists; California. (e) X-ray technician; student health department; California. MH7-8

MEDICAL RECORD LIBRARIANS — (a) Chief, 500-bed general hospital; attractive city, outside US. (b) Professional organization, sponsored by ACS, AMA, AHA; considerable travel. MH7-9

PUBLIC HEALTH—Public health workers interested in overseas positions; $5000-$14,000. MH7-10

SUPERVISORS—(a) Supervise and teach, nursing personnel, new 60-bed patient unit; clinic and hospital serving industrial group, south, $535. (b) Pediatric; 300-bed teaching hospital; 55-bed department; university city, southwest. (c) Operating room; 500-bed general hospital; California $450-$500. MH7-11



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ADMINISTRATORS — (a) Director, medical education; MD to coordinate new intern and resident program; also assist new nurses training school and OPD (100,000 visits, 350-bed hospital); outstanding facility; $15-$20,000; south. (b) FACHA capable taking over full range hospital administration, both medical and non-medical; 200-bed, accredited general hospital; east. (c) 2 fully-approved hospitals, 800-beds; coordinate hospital, medical and administration functions; requires extensive experience; prefer FACHA; substantial. (d) Direct 60-bed hospital and act as consultant in opening 4 additional small hospitals; will direct each hospital as they open; excellent opportunity achieve directorship group, 10 hospitals; requires at least Nominee ACHA; $15,000 start; Southern California. (e) Administrator, 8-10 years experience, hospital 150-200 beds; $10-12,000; lovely town, southeast. (f) 30-beds to be built; will expand to 80; $8,000; uranium capital of U.S.; west. (g) 175-bed, general, teaching hospital requires FACHA able direct 200-bed expansion; $15-20,000; midwest.

ASSISTANT ADMINISTRATORS — (h) 2,000-bed hospital; requires degree in Hospital Administration or three years experience as an assistant administrator; $6-7,000; near Los Angeles. (i) 200-bed, JCAH, general hospital; prefer one single; salary open to discussion; town 40,000 on Great Lake. (j) To direct fairly large TBc unit of 1000-bed hospital association; opportunity advance; Southern California. (k) To direct 100-bed, fully approved pediatric hospital, unit 4 specialized hospitals, composing important medical center; excellent potential; university city near New York City.

ADMINISTRATIVE POSTS — (1) Business Manager; 5-6 years experience—good accounting background; able direct department 40 people; 350-bed, fully approved, medical school affiliated hospital; to $7,200; large city, midwest. (m) Purchasing agent; 300-bed, fully approved hospital, unit of 10 hospitals; excellent opportunity advance; about $9,000; college town 100,000; midwest.

EXECUTIVE HOUSEKEEPERS — (a) Full charge modern, busy department; 300-bed voluntary general hospital; lovely southern college city. (b) Also responsible nurses home, house officers' residences; fully approved general hospital 375 beds; large New England city. (c) 300-bed general hospital; city 75,000 centrally located to 3 larger cities; mideast. (d) Supervise 75 on staff, hospital to expand shortly from 275-beds; important Midwestern university city. (e) Full charge department, fully approved voluntary general hospital 300-beds; ideally located, Pacific Northwest; large city. (g) Replace housekeeper retiring from 20 years' service; must be able reorganize department, participate actively in building program to 450-beds; east.

(Continued on page 154)

MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS — (a) 700-bed hospital; west state; salary open. (b) 800-bed State hospital; New England; salary plus new 3 bedroom house. (c) 60-bed hospital; south; salary open. (d) 40-bed hospital; south; salary open. (e) 125-bed hospital; north central; salary $8,500. (f) 100-bed hospital; Massachusetts; salary open. (g) 45-bed hospital; Connecticut; salary open.

ASSISTANT ADMINISTRATORS — (a) 350-bed hospital; south; salary $7,200. (b) California; salary $600. (c) 300-bed hospital; south; salary open.

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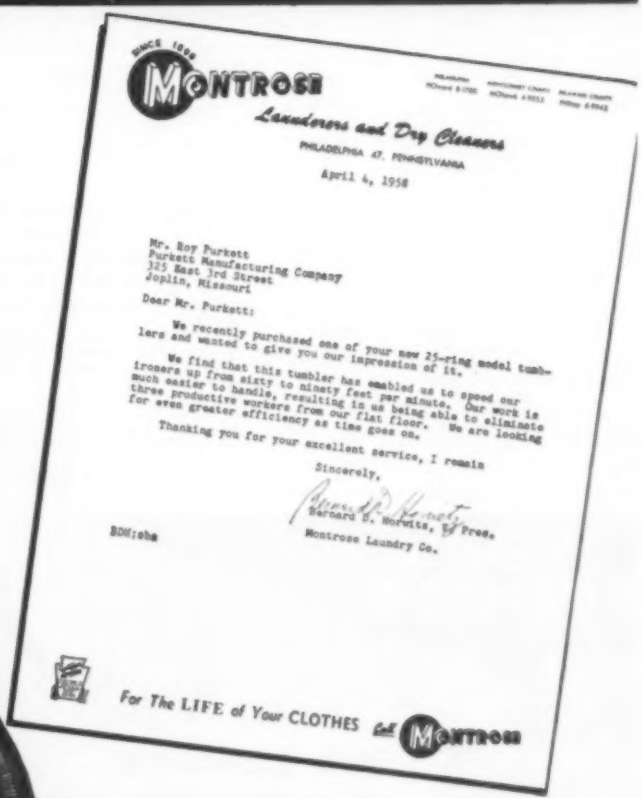

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April 4, 1958

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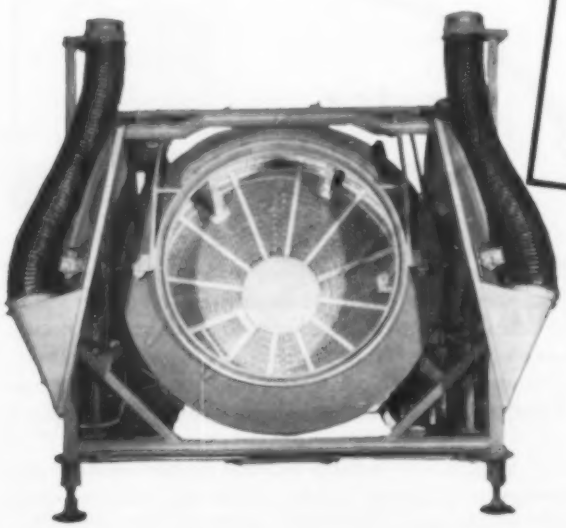


* Pre-Drying Conditioning Tumbler

Purkett qualified engineers will assist you with your laundry, linen and garment conditioning problems . . . . without obligation, of course.

Write or phone for literature.

Naturally it's a PURKETT®

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY
Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—*Continued*

NURSE ANESTHETIST ADMINISTRATORS—(a) 50-bed hospital south; seeking male nurse administrator; salary open. (b) 55-bed hospital; Connecticut; seeking male or female nurse anesthetist to serve as administrator. (c) New 45-bed hospital; Utah; seeking combination male or female anesthetist to serve as administrator.

ANESTHESIOLOGISTS—(a) M.D. for beautiful 100-bed hospital in Florida on the Coast; resort area; hospital JACH approved; no other M.D. anesthesiologists in area; several large hospitals in area; salary open. (b) several large hospitals in New England states.

BUSINESS MANAGERS—(a) 350-bed hospital; south; Gulf Coast; salary open. (b) 500-bed State hospital; East Coast; salary open. (c) 400-bed hospital; new; salary open.

FOOD SERVICE MANAGERS—(a) Large hospital; metropolitan city; Utah; $600. (b) 300-bed hospital; Michigan; salary open. (c) 400-bed hospital Missouri salary $8,500. (d) State hospital; south; salary open.

LABORATORY TECHNICIANS—(a) Neuro-Histology technician; New England; salary open. (b) Bio-Chemist; MS level; New England; salary open. (c) Bacteriologist MS level; salary $500 to $650. (d) Chief laboratory technician; male or female; ASCP registered $500 to $600. (e) Laboratory technician; ASCP all areas; $400 to $450.

PHARMACISTS—(a) Chief; Col. Teaching hospital; salary open. (b) 300-bed hospital; Ohio; salary open. (c) State hospital; Ohio; salary open. (d) East Coast; salary open.

LIBRARIANS—Registered or equal; 100-bed hospital; Chicago; salary $400 and up. (b) Florida; 200-bed hospital; salary open.

DIRECTORS OF NURSES—(a) 300-bed hospital; Carolina; M.S. Degree required; school as college affiliation. (c) 300-bed Sisters hospital; south; NLNE Accredited school of nursing.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ASSISTANT ADMINISTRATOR—(a) M.H.A. Degree; 150-bed hospital, Indiana. (b) 300-bed hospital, Pennsylvania. (c) Experience; 200-bed eastern hospital.

ADMINISTRATOR—(a) 100-bed Ohio hospital. (b) 60-bed hospital, Wisconsin. (c) 65-bed hospital, Pennsylvania; open September.

(Continued on page 156)

INTERSTATE—*Continued*

BUSINESS OFFICE MANAGER—(a) Comptroller; 370-bed hospital, southeast. (b) 175-bed hospital, east. (c) Accountants; $6,000.

DIRECTOR, PUBLIC RELATIONS—East.

DIRECTORS, NURSING SERVICE—Directors, schools of nursing; attractive salaries.

MEDICAL RECORD LIBRARIANS—To $6600.

EXECUTIVE HOUSEKEEPER—(a) 300-bed hospital; Pennsylvania. (b) New hospital, midwest; 220-beds. (c) 350-bed Ohio hospital. (d) 275-bed hospital, New York State. (e) Assistants; Ohio, $250.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Business manager; southwest; 120-bed hospital in city of 50,000. (MH-2054) (b) Cost accountant; middle west; Degree in accounting; 225-bed hospital; to $7200. (MH-1691) (c) Personnel director; middle west; 300-bed hospital; man or woman. (MH-1941) (d) Purchasing agent; east; near New York City; 300-bed hospital. (MH-1986) (e) Business manager—train for administrator; south; 200-bed hospital; good accounting background. (MH-2025) (f) Business manager; middle west; 350-bed hospital; new position; good accounting and administrative experience; supervise 40 employes; $7200. (MH-1974).

EMBLEM OF EXCELLENCE IN VERTICAL TRANSPORTATION

HAUGHTON REPORTS
TO THE NATION'S HOSPITALS

Present Standards for HOSPITAL ELEVATORS Need Changing, Too!

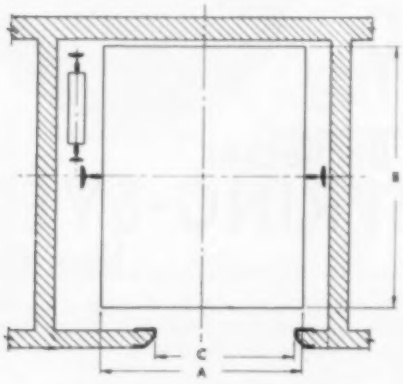
Current standards for hospital elevators recommend inside car width of 5'4" and depth of 8'0" for elevators rated at 3500 lbs. load capacity. For elevators rated at 4000 lbs., recommended width is 5'8" and depth 8'4".

In neither case are the recommended dimensions nor load capacities adequate for today's hospital needs.

You can readily see why this is so in much of the equipment used daily by hospitals. For example—many hospital beds, with attachments, run over 8½' in length . . . an impossible "fit" in an 8' car. And some of the new, improved iron lungs are also too large for elevators designed according to present standards.

There are numerous other examples, of course, that make it clear present standards are inadequate. That is why Haughton engineers, when designing equipment for hospital elevator modernization or new construction, look beyond these standards—recommend equipment for today's hospital needs.

It will pay you to call on Haughton for vertical transportation that's a credit to your hospital . . . and a pattern for new hospital elevator standards most urgently needed.



HOSPITAL ELEVATOR STANDARDS RECOMMENDED BY HAUGHTON

LOAD	DIMENSIONS		
	A	B	C
4000 lbs.	5'4"	9'0"	4'
4500 lbs.	5'8"	9'6"	4'
5000 lbs.	6'0"	9'6"	4'

GET A PROPOSAL FROM HAUGHTON . . . for elevator modernization, installation, maintenance or service—62 Branch Offices to serve you.

Haughton Elevator Company

DIVISION OF
TOLEDO SCALE CORPORATION

Executive Offices and Plant
Toledo 9, Ohio

classified advertising

POSITIONS OPEN

SHAY—*Continued*

DIRECTOR SCHOOL OF NURSING EDUCATION—University; new school being organized; M.S. Degree plus demonstrated administrative ability; to $10,000. (MH-2003)

DIETITIANS—(a) Chief; south; 300-bed hospital in city of 100,000; $6600. (MH-1140) (b) Therapeutic; middle west; 120-bed hospital; special diets and manage kitchen; do buying; $4800 up. (MH-1942) (c) Assistant director; dietary department of large university medical center; opening new kitchen facilities and new cafeteria; to $6000. (MH-1877) (d) Chief; middle west; 175-bed hospital; to $7200. (MH-1893) (e) Chief; east; large hospital; 92 employes in department to $6000. (MH-1999).

MISCELLANEOUS

SELLING HOSPITALS?

CARRYING A SIDELINE

interest you? Then AAA-1 Company is looking for you. Products top quality in their field, enjoy national distribution. Basis strictly commission, 15%. Apply MS 17, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

PLACEMENT BUREAUS

DOROTHEA BOWLBY ASSOCIATES

8 South Michigan Avenue Chicago 3, Ill.

Suite 618—ANdover 3-5293

Dorothea Bowlby, Director

A Specialized Employment Service for Medical and Hospital Personnel. (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Directors of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers. All inquiries from applicants are kept strictly confidential.

INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.

Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

(Continued on page 158)

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

11 West 42 Street New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

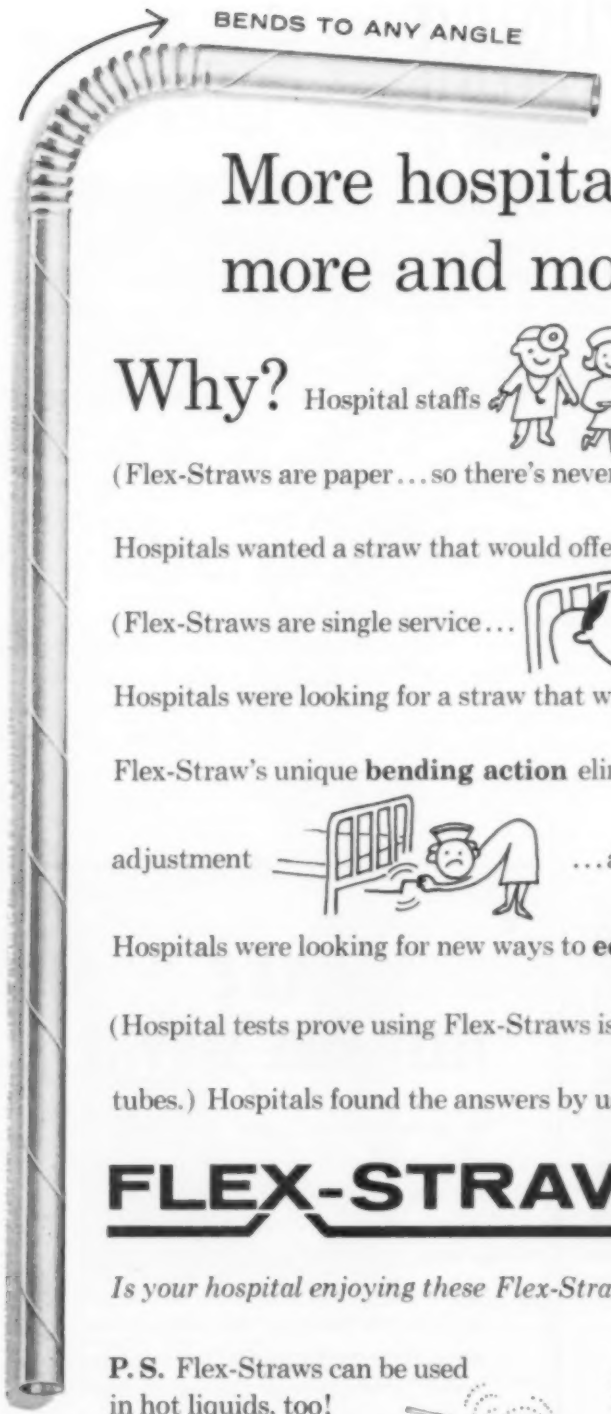
FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency



More hospitals are using more and more Flex-Straws!

Why? Hospital staffs wanted a straw that was **safe**

(Flex-Straws are paper... so there's never any danger of broken glass.)

Hospitals wanted a straw that would offer their patients added **cleanliness**

(Flex-Straws are single service...  they're always fresh as a daisy.)

Hospitals were looking for a straw that was **convenient** and **efficient**.

Flex-Straw's unique **bending action** eliminates lost motion in patient bed

adjustment ...and Flex-Straws are **disposable** too.

Hospitals were looking for new ways to **economize** 

(Hospital tests prove using Flex-Straws is more economical than using breakable tubes.) Hospitals found the answers by using...

FLEX-STRAWS®

Is your hospital enjoying these Flex-Straw advantages?

P. S. Flex-Straws can be used in hot liquids, too!

refer to
HOSPITAL PURCHASING FILE
for listings and prices
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FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

FOR RENT

Ex-Hospital Building available FOR RENT: to be converted into NURSING HOME for approximately 40 patients; Southern Illinois Community; only experienced operators should submit offers. Reply P. O. Drawer 100, Rosiclare, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

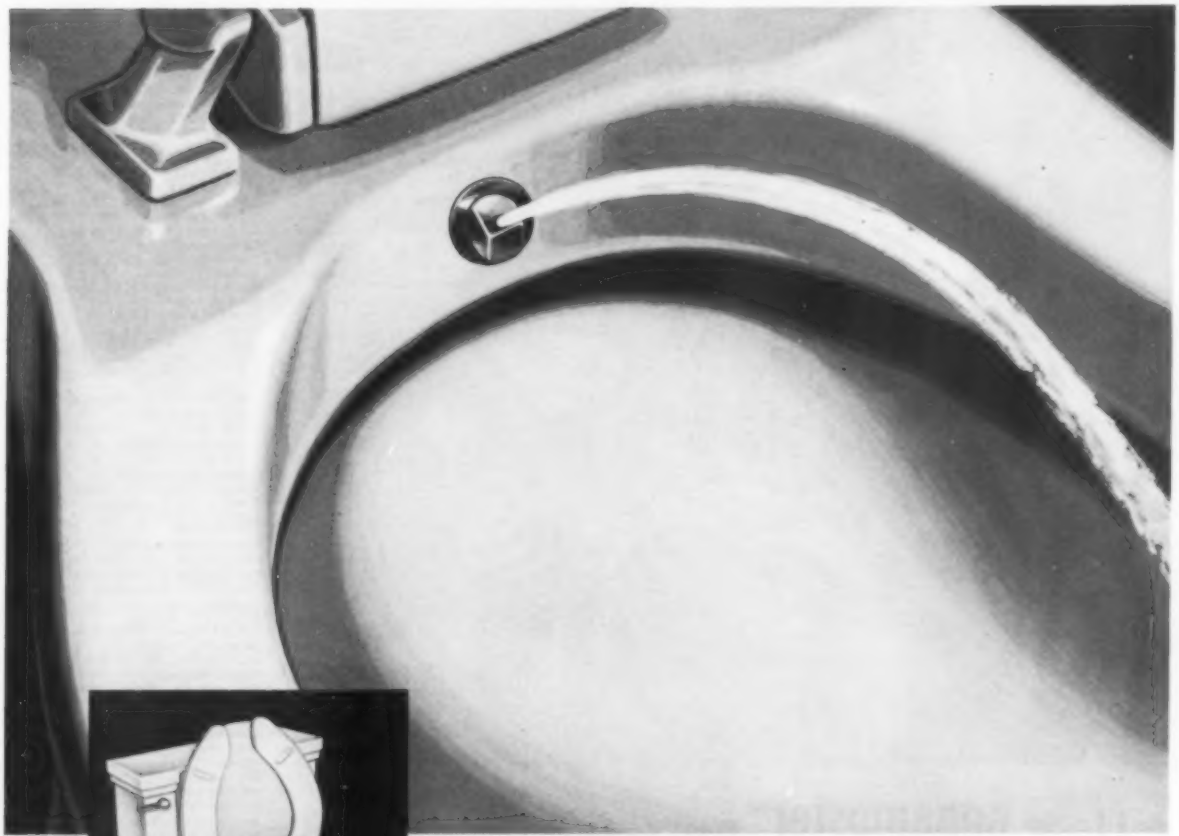
The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

SCHOOLS—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

New American-Standard toilet affords patients greater personal cleanliness unaided...



NEO-HEALTH TOILET has hygienically designed posture bowl and seat for using the cleansing spray.

American-Standard and "Standard"® are trademarks of American Radiator & Standard Sanitary Corporation

Built-in spray of water permits thorough personal cleansing

This new American-Standard hygienic toilet is ideal for private and semiprivate rooms. The gentle spray of water offers the advantage of frequent and thorough personal cleansing. And since patients operate it themselves, valuable nursing time can be saved. A handle, conveniently located beneath the tank, releases the water from a separate compartment in it. At time of installation, provision can be made to supply warm water to the tank. The Neo-Health is made of tough non-absorbent vitreous china in eight popular colors and white.

FOR MORE INFORMATION on the Neo-Health toilet, a new concept in personal sanitation, write AMERICAN-STANDARD, PLUMBING & HEATING DIV., 40 W. 40th St., New York 18, N. Y.

AMERICAN-Standard PRODUCTS

AMERICAN-Standard

PLUMBING AND HEATING DIVISION

How pagemaster® serves the needs of an expanding medical center

This large, midwestern University Medical Center gets instant contact with key personnel with a PAGEMASTER *Selective Radio Paging System* by Stromberg-Carlson.

Coverage is complete throughout the campus, with signals reaching up to a radius of 3 miles in this particular installation.

Starting with a few dozen receivers, the Center can expand its system to full capacity of over 450 receivers to meet growing needs. There is *no additional installation cost.*

Key people are equipped with these transistorized pocket-size receivers. When any of them is called, but is away from his usual location, the telephone switchboard operator sets his *private signal* on the PAGEMASTER encoder (a unit of adding machine size next to the switchboard) and flips a switch.

Instantly that individual's receiver—and *only* his—responds with a pleasant but commanding signal. He picks up the nearest telephone and reports. The signal automatically repeats every 20 seconds until the call is answered.

PAGEMASTER selective radio-paging can meet *your* need for fast contact with key people—whether yours is an educational, industrial or commercial organization, in one building or many. You can have a system tailored to your own requirements, whether you need just a few receivers—or several thousand. *Systems are available for lease or purchase.*

For details contact the PAGEMASTER distributor in your area. Or write to us at 202 Carlson Road.

"There is nothing finer than a Stromberg-Carlson"

STROMBERG-CARLSON

A DIVISION OF GENERAL DYNAMICS CORPORATION

Pagemaster Sales • Rochester 3, N.Y.

Electronic and communication products for home, industry and defense

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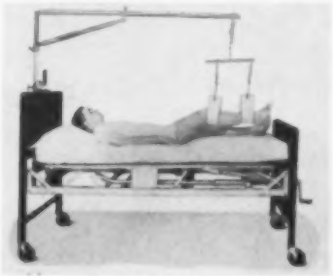
Hawaii: Welton & Co., Honolulu

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 180. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Leg Exerciser
Fits Any Standard Bed

The Zimmer No. 947 Leg Exerciser, which may also be used to exercise the arm and shoulder, is constructed for at-



tachment to any bed of standard dimensions. Octagon aluminum tubing is used to form the exerciser which is attached to the bed with Zimmer 640 toggle clamps. The slings and rocker arm are connected to the tubing with chains and are adjustable for proper lift to balance the leg. The leg can be moved in any desired direction or the unit may be locked in abduction position. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #874 on mailing card.

Ideal Mealmobile
Has Power Drive

A new propelling accessory has been added to the Model 9020BCT Ideal Mealmobile. The complete food service conveyor, handling hot and cold foods and beverages, is now equipped with special battery powered drive mechanism for ease of movement of the cart over long distances or up grades. Push button controls are conveniently located on the push handle of the cart. A forward and reverse lever make change of direction quick and

easy for the operator. Also on the push handle is a high torque button for use in providing additional power and speed for steep grades when the cart is fully loaded.

The new mechanism gives the Mealmobile a speed of from two and one-half to three and one-half miles per hour forward and a mile and one-half per hour in reverse. The six-volt automotive type battery is enclosed in a stainless steel compartment and is designed for long use. A self-regulating charger automatically charges the battery when the cart is plugged in for preheating and prechilling. The charger automatically cuts out of circuit when the battery is fully charged. The propelling accessory is available for use with all other Ideal carts and can be installed either at the plant or at the hospital. **The Swartzbaugh Mfg. Co., Murfreesboro, Tenn.**

For more details circle #875 on mailing card.

Aloe-Narda Sonic-Cleaner
Has Large Capacity Tank

The Aloe-Narda Sonic-Cleaner employs high frequency sound waves which create water vibrations to dislodge blood and foreign matter from instruments, syringes, needles and glassware. Joints, crevices and locks of instruments and other hard-to-clean items are completely clean in minutes. The large five-gallon stainless steel

tank accommodates over eight dozen average sized instruments for each three-minute cleaning cycle. A small amount of liquid detergent is used in the water for thorough cleaning in the Sonic-Cleaner which is simple to operate. Instruments and other items need only be rinsed after removal from the cleaner. A great saving in time is effected and the new unit is priced for hospital budgets. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #876 on mailing card.

Modern Nursing Tool
Offered in Patient Kard System

The culmination of three years of study, research and planning, the new Debs Patient Kard System is designed to communicate instructions visually to all who have contact with the patient. In service 24 hours a day, PKS comprises the PKS Dispensing Rack, an attractive, durable plastic rack containing a supply of each of the printed Instruction Kards, and a smooth plastic plaque for holding special instructions for each patient. The plaque has pressure-sensitive backing for easy installation on wall or bed.

(Continued on page 162)

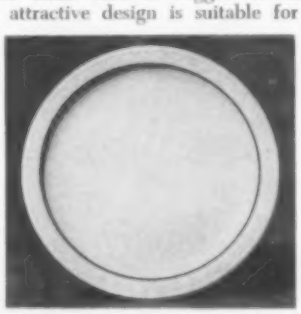
When a patient is admitted, the Name Kard is initiated and placed on the top space of the Instruction Plaque. Orders or changes of orders are then dispensed

by the supervisor through the Instruction Kards which are color coded for quick identification of conditions and services. They are attached to the plaque in view of the patient and all personnel, facilitating correct care. The color coded Instruction Kards cover nursing, dietary, laboratory and general classifications. The PKS is simple, speedy and efficient and helps to assure correct patient care. **Debs Hospital Supplies, Inc., 5990 Northwest Highway, Chicago 31.**

For more details circle #877 on mailing card.

Syracuse Cardinal China
Is Distinctive and Strong

Simple, distinctive styling characterizes the new Cardinal Pattern in Syracuse China. It is one of the 23 designs now available in Hospitality patterns for hospital and other institutional food service where china receives rugged treatment. The attractive design is suitable for use



with all decorative plans, and the high-fired construction of the china, with steel-hard glaze, ensures sanitation and long life. Replacement costs are low due to the unusual durability of china. **Syracuse China Corp., 1858 W. Fayette St., Syracuse, N.Y.**

For more details circle #878 on mailing card.

WHAT'S NEW

Chair and Ottoman Have Foam Rubber or Spring Cushions

Wall and space-saving features are incorporated into the new chair and ottoman

combination designed for hospitals by Colin Campbell McLean. It serves as a restful seat for bed-weary patients, either with or without the self-contained ottoman which rolls easily under or out from the chair on casters. The frame is constructed of Northern Hard Maple and cushions on both chair and ottoman are available with full foam rubber or full spring construction. **American Chair Co., 911 N. 11th St., Sheboygan, Wis.**

For more details circle #879 on mailing card.

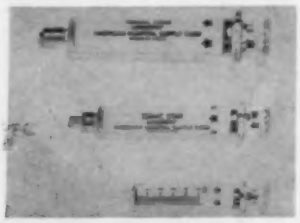
Trouble-Free Cord Set for Nurses' Call System

Designed for use on any locking button type of nurses' call system, the new Edwards cord set is formed of shock resistant nylon. It is trouble-free and maintenance-free, since the vinyl cord and molded plug are practically unbreakable. The molded nylon shell withstands repeated shocks, it turns without twisting cord or wires, and has no exposed screws or parts. The plug is molded on the cord and rugged molded-in prongs hold the cord securely in the wall receptacle. The new unit is available for single or double cord sets. **Edwards Co., Inc., Norwalk, Conn.**

For more details circle #880 on mailing card.

Interchangeable Syringes Have Identifying Stars

A row of stars on barrel and plunger identify syringe parts at a glance for speedy accurate assembly. In the new line of Tomac Star Interfit Interchangeable Syringes a perfect fit is assured as every plunger fits every barrel of the same size. Both barrel and plunger are individually ground for maximum resistance to wear



and breakage and the Interfit Syringes are available in metal, luer-lock and glass tips. They are made of "tuffenized" glass with graduations permanently etched into the barrels. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #881 on mailing card.

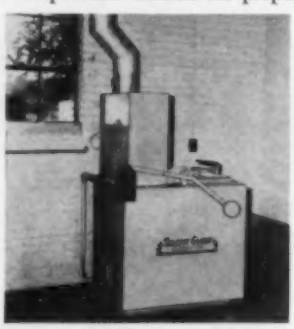
Staph Infections Killed By Ioclide Germicide

A new and highly potent germicide which is described as lethal to the highly resistant strains of staphylococci aureus is offered in Ioclide. A non-selective, water-soluble iodophor germicide which kills spores, viruses and bacteria, including tubercle bacillus, Ioclide is non-toxic in use dilutions. It is designed for disinfection of instruments and utensils of polyethylene, glass, enamel, rubber or metal. It is quick-acting, in stated dilutions, has excellent penetrating and cleaning properties, has no appreciable odor and is stable and water soluble in all concentrations. It can also be used for pre-surgical scrub. **Clay-Adams, Inc., 141 E. 25th St., New York 10.**

For more details circle #882 on mailing card.

Medical Waste Fully Destroyed in Crematory Destructor

Diseased organic matter and other medical waste is completely destroyed in the newly developed medical crematory destructor. There is no odor, smoke or fly-ash in the operation. Fired with Silent Glow Oil Burners with automatic ignition, the destructors are equipped with automatic temperature controls for proper de-



struction. An automatic timer is set by the operator for the required destruction time for different types of charges, automatically shutting off when time is elapsed. Controls prevent the opening of the charge chamber door until the necessary temperatures are reached and destruction is completed. **Silent Glow Oil Burner Corp., Medical Disposal Div., Hartford 1, Conn.**

For more details circle #883 on mailing card.

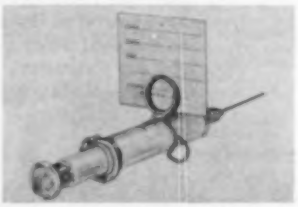
Two Colorful Developments in Wall and Floor Tiles

A whole new range of beautiful effects can be achieved with the two new tiles introduced by American-Olean Tile Company. The new crystalline glazes were developed especially for use on floors, countertops and window sills. Scored Tiles with Crystalline Glazes are a new type of tile permitting unlimited design opportunities for floor and wall treatments with a rich appearance, yet with economical installation cost. They combine the flexibility of small unit design with the economy and easy installation of larger self-spacing units. Scored Tile is a 4¼-inch square glazed interior tile with straight grooves cut into the surface. Both new tiles are available in 13 colors. **American-Olean Tile Co., Lansdale, Pa.**

For more details circle #884 on mailing card.

Syringe Card Clips Help Avoid Confusion

Medicine card inserts fit firmly into the coil at the top of the new Syringe Card Clip which presses down over the barrel of the syringe and locks into position. The



clip holds a loaded syringe level in elevated, sterile position on any smooth, rigid surface, keeping needle and plunger ends free from contamination. At the same time, the card ensures identification of the syringe contents. **Meinecke & Co., Inc., 225 Varick St., New York 14.**

For more details circle #885 on mailing card.

High Sound Absorption in Embossed Travertone

"Ridges and valleys" that are directional but irregular furrow the face of the new Embossed Travertone mineral wool acoustical material introduced by Armstrong. The relief surfaces not only contribute to the design, but give the acoustical tile high sound-absorption efficiency. The acoustical properties of the new material are said to be comparable to those of standard fissured mineral tile.

Available in 12 by 12-inch tiles, ¾-inch thick, the new material is factory-coated with a white latex paint finish and is incombustible. It may be cemented to an existing ceiling or installed through mechanical suspension. It is easily cleaned and may be repainted without appreciable loss of acoustical efficiency. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #886 on mailing card.

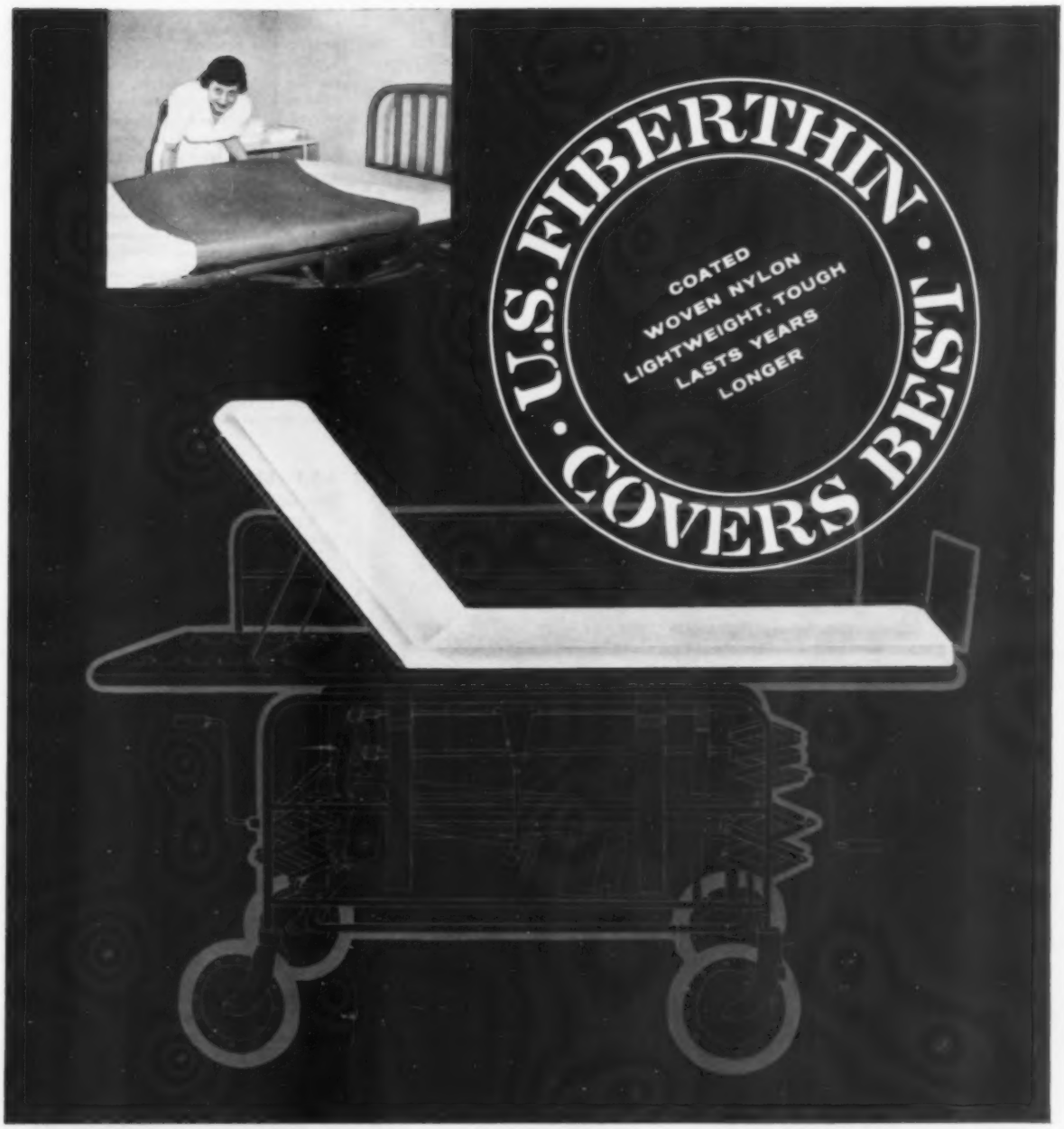
Island-Type Work Table Is Versatile Unit

Designed particularly for central sterilizing, the new Maysteel island-type work table is a versatile unit. Multiple sorting bins are accessible from both sides of the unit which has a stainless steel top. A choice of base units, with drawers and open or closed shelves opening on either side, is available. The 48-inch wide table

can be built to any length desired, with the base unit finished to match interior decoration. **Maysteel Products, Inc., 740 N. Plankinton Ave., Milwaukee 3, Wis.**

For more details circle #887 on mailing card.

(Continued on page 164)



U. S. FIBERTHIN®—WATERPROOF... LONG-WEARING... RESISTS HOSPITAL STAINS

For hospital beds and stretchers, U.S. Fiberthin has proved itself the best all-around protective sheeting on the market. Woven with ribbon-like threads of durable nylon, coated with either vinyl or neoprene, this modern covering fabric will not absorb the slightest bit of moisture. It protects completely against sheet and mattress damaging hospital stains. Nurses like U.S. Fiberthin because it is so extra light and easy to handle. Easy to launder, U.S. Fiberthin will withstand repeated autoclaving and outlasts other types of protective sheeting. Ask your supplier for U.S. Fiberthin—in rolls that can be cut to any size, or be made into fitted covers as shown above. For additional information, write United States Rubber, Mishawaka, Indiana.

US RUBBER **United States Rubber**

Mishawaka, Indiana

WHAT'S NEW

Thinlite Curtain Wall System Is Complete Enclosure Element

When the elements of the new Thinlite Curtain Wall System are put in place, the wall of a building is completely finished, both inside and out. Thinlite glass units are hollow, two inches thick and 12 inches square. They are assembled at the factory in panels two feet high and either four or five feet wide. Panel perimeters are extruded aluminum which interlock with each other for quick and easy installation. In addition to the panels, the Thinlite Curtain Wall System includes a line of aluminum parts such as sill, jamb, head members and connectors. When panels are bolted into place, gaskets are compressed and automatically form a weatherproof vertical joint. Struts may be used either on the inside or the out-

side of the building. The attractive and practical system can be installed in record time, a whole side of a building being finished in a day after the basic skeletal structure is erected.

Adapted to buildings of all types, including schools, hospitals, colleges, libraries and other institutions, the Thinlite system is the result of three years of exhaustive studies and engineering. Basic daylighting panels are available in a soft white for general use, a cool blue-green for severe sunlight exposures, and a golden yellow for non-sun exposures. The basic panels are supplemented with colorful Thinlite ceramic-faced glass panels, vista panels (for vision), decorative glass unit panels, porcelain and other special type panels for flexibility of design. Window panels can be either fixed or projected and arranged in any design desired. Each panel is interchangeable with any other panel. **Owens-Illinois Glass Co., Toledo 1, Ohio.**

For more details circle #888 on mailing card.

A.S.R. Blade Dispensers Supplied at No Cost

A new policy for supplying A.S.R. Steri-Sharp surgical blade dispensers is announced by A.S.R. Hospital Division. Any hospital using A.S.R. Steri-Sharp surgical blades will be supplied with enough of the stainless steel blade dispensers to equip operating rooms, emergency rooms and central supply by requesting the dispensers from the manufacturer. **A.S.R. Hospital Division, 380 Madison Ave., New York 17.**

For more details circle #889 on mailing card.

Smooth Polyfilament Suture in Autoclavable Container

The new Supramid Extra Non-Sterile Suture in balls of 164 feet is supplied in a unique plastic container which permits autoclaving of the complete unit whenever sterile suture is needed. Neither suture nor container is harmed by repeated sterilization. Supramid Extra is also available in sterile form in hermetically sealed envelopes, each containing 50 inches of suture with swaged on needle.

Supramid Extra is a polyfilament synthetic surgical suture which is new in construction and strength. Several strands

are enclosed within a smooth cover, forming a microscopically smooth surface, preventing stitch irritation and growth of tissues into the suture. It is non-absorbable but heals up perfectly in the tissues without irritation. **Dr. S. Jackson, 4713 Colorado Ave., N.W., Washington 11, D.C.**

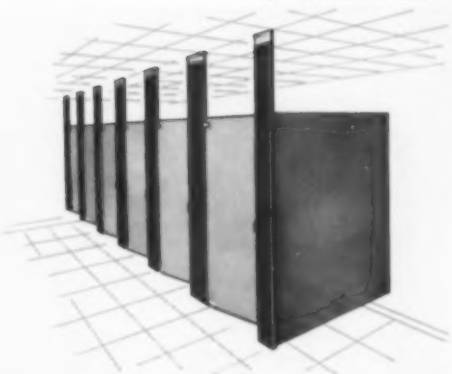
For more details circle #890 on mailing card.

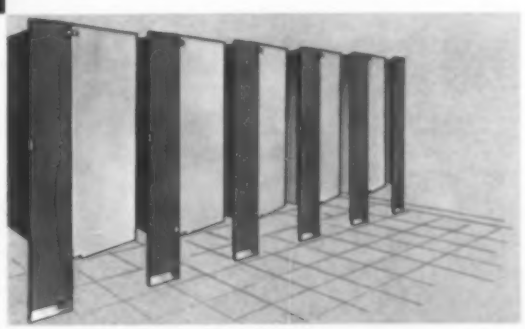
(Continued on page 165)

"WEIS WAS WISER!"

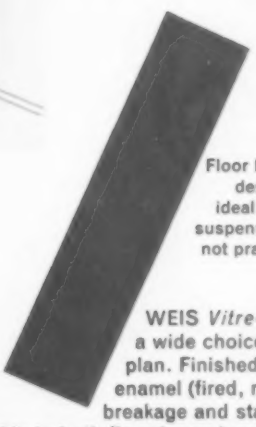
Architects, building owners and tenants become fully aware of WEIS toilet compartment advantages the second or third year after installation. That's when their original choice is confirmed, when they can say with firm conviction, "Our choice of WEIS was wiser!"

Ceiling-hung design is the ultimate for ease of floor maintenance





Floor braced design is ideal where suspension is not practical.



WEIS *Vitre-Steel* toilet compartments are available in a wide choice of colors to harmonize with any decorating plan. Finished inside and out in vitreous porcelain enamel (fired, not baked), Weis compartments are not subject to breakage and staining. Nor do they present costly installation problems. Available in both floor-braced and ceiling-hung designs. See Sweet's Architectural File, No. 22b/We—or write for complete information.

Henry Weis Manufacturing Company, Dept. H-1807, Elkhart, Indiana

Weis Vitre-Steel compartments have been selected for prominent buildings designed by the following architects: Bastille Halsey Assoc., Boston, Massachusetts; Perkins & Will, Chicago, Illinois; Raymond E. Maritz & Son, Inc., St. Louis, Missouri; John E. Ramsey, Jr., Salisbury, North Carolina; Robert E. Alexander, Jr., & Assoc., Dallas, Texas; Richer & Axt, West New York, New Jersey; C. E. Silling & Assoc., Charleston, W. Virginia; Raymond Harry Ervin, Denver, Colorado.

WEIS
VITRE-STEEL
PORCELAIN ENAMEL
TOILET COMPARTMENTS

WHAT'S NEW

Smaller Cafeteria Tables With Space Saver Trays

Cafeteria trays are now available in a new design to occupy less area, permitting

the use of smaller tables, thus increasing room capacity. They also encourage personnel to keep dishes on trays while eating, facilitating clean-up. The design permits placing four on a 36-inch square table with condiments in the center.

The Toteline Space Saver Trays Number 429-7 are made of fiber glass and reinforced plastic. They are available in red, lemon-yellow, mint-green and pearl gray. The smooth surface and rounded corners facilitate cleaning. **Molded Fibre Glass Tray Co., Linesville, Pa.**

For more details circle #891 on mailing card.

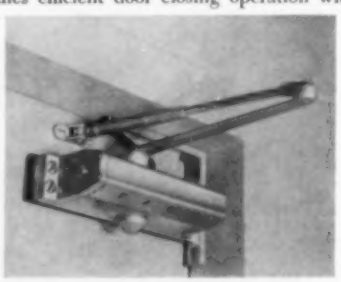
Super-Concentrated Detergent Offered in Liquid "K"

A top quality cleaner with stable suds is offered in Klenzade Liquid "K" Detergent Concentrate. It is easy on the hands and can be accurately dispensed with the Klenzade Jug Pump. The highly concentrated compound has high soil-holding capacity, requiring only small amounts in dilution for effective cleaning. It is equally effective in cleaning pots and pans and delicate painted surfaces. **Klenzade Products, Inc., Beloit, Wis.**

For more details circle #892 on mailing card.

Compact, Attractive Unit for Efficient Door Closing

A new rack and pinion door closer designed with an adjustable compression spring is now available from Yale and Towne. Developed by the research division of that company, the new unit combines efficient door closing operation with



attractive appearance and compact size. The new features make the closer particularly valuable on exterior doors where wind is a factor and on any door where drafts must be considered. The new Yale 80 line of door closers features an internal expansion chamber which absorbs extreme pressures and prevents leakage. A single valve screw provides easy two speed control of the closing and latching action. **The Yale & Towne Mfg. Co., 11 S. Broadway, White Plains, N.Y.**

For more details circle #893 on mailing card.

A REMINDER FROM MERCK SHARP & DOHME:

NOW IS THE BEST TIME TO ORDER ASIAN FLU VACCINE

Recent outbreaks of influenza indicate the possibility of a recurrence of Asian Influenza in the United States in late 1958 or early 1959. Ordering your requirements <u>now</u> will assure you of sufficient vaccine when it is needed.

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
FIRST CLASS PERMIT No. 2048, Sec. 34.9, P.L.&R. PHILADELPHIA, PA.

TEAR OUT

MERCK SHARP & DOHME
Vaccine Department
640 North Broad Street
Philadelphia 1, Penna.

Remember how difficult it was to obtain Asian Influenza vaccine during the past flu season?

To make certain that you have an adequate supply when the need again arises, you should order vaccine *now*. Order for immediate delivery or, if you prefer, at whatever future date you specify.

Vaccination against Asian Influenza is inexpensive—and is the only effective way of minimizing the risk of contracting this highly contagious disease which causes so much debilitation and absenteeism.

By anticipating your needs and ordering now, you can be certain that you will have enough vaccine for your personnel and patients.

Influenza Virus Vaccine Monovalent

400 C.C.A. units Asian Strain per cc.
Recommended adult dose: 1 cc. intramuscularly in early autumn.

Influenza Virus Vaccine Polyvalent

200 C.C.A. units Asian Strain
100 C.C.A. units PR8
100 C.C.A. units PR301
100 C.C.A. units Great Lakes
500 C.C.A. units Total

Recommended adult dose: 1 cc. intramuscularly in August or September, followed by 1 cc. intramuscularly three months later.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

MERCK SHARP & DOHME
VACCINE DEPARTMENT
640 NORTH BROAD STREET
PHILADELPHIA 1, PENNA.

Please ship the following to arrive on _____
(specify delivery date)

_____ *10 cc. vials Influenza Virus Vaccine Monovalent*

_____ *10 cc. vials Influenza Virus Vaccine Polyvalent*

Ship to: _____
(Street address)
(City and State)

Bill to: _____
(Street address)
(City and State)

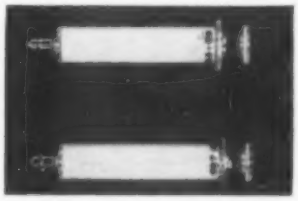
Purchase order number _____

TEAR OUT

WHAT'S NEW

McKesson Syringe Line Formed of Kimble Resistant Glass

Exacting inspection standards of raw materials and of production of the new line of McKesson Syringes ensure quality



surpassing government specifications. Made of Kimble resistant glass, the syringes are formulated to withstand many hours of sterilization and to resist sudden thermal changes. Scientific annealing minimizes breakage due to internal strains and the permanent opaque markings are embedded in the glass. A complete line of regular and interchangeable hypodermic syringes available with metal, lock or glass tips is now available from McKesson. The new interchangeable syringes ensure a perfect fit of any barrel and plunger of identical size. **McKesson & Robbins, Inc., 155 E. 44th St., New York 17.**

For more details circle #894 on mailing card.

Ortho-Therapy Bed Serves as Patient Transfer

Patients too weak or ill to be transferred to a chair or to a tilt table for therapy, can be comfortably handled in the new Franklin Ortho-Therapy Bed. It is designed for use in the treatment of cardiac complications and where post-surgery and physical therapy are required. The bed is an aid to patients who need elevation by progressive steps to an upright position. It has all of the standard hospital bed positions, plus features of tilt tables, including a full range of adjust-

ment from 10 degree Trendelenburg position through horizontal to 90 degrees or full standing position. The patient can walk on or off the foot rest from the full standing position.

The new bed is powered by silent electric motors and all adjustments are made by the operator or the patient by means of a portable remote-control switch. The complete line of accessories increases the range of treatment possible with the bed. **Franklin Hospital Equipment Corp., 116 Academy St., Newark 2, N.J.**

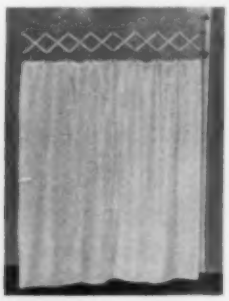
For more details circle #895 on mailing card.

(Continued on page 166)

WHAT'S NEW

Aluminum Extension Screen Pivots in Wall Fixture

A new aluminum extension screen, anodized for wear resistance, is available for



screening a bed, a room or doorway or for creating a cubicle. A wall fixture supports the screen and permits free pivoting of the unit with vinyl or muslin curtain. The extension screen folds compactly or flat against the wall, yet extends to 70 inches long. **Beam Metal Specialties, 25-11 49th St., Long Island City 3, N.Y.**

For more details circle #896 on mailing card.

Hot Food Vendor Has 70-Can Capacity

A new model of the hot food vendor for Campbell soups and other food products is now available with a 70-can capacity. The VS-7 is thermostatically controlled to serve food piping hot. It is designed to fit virtually all locations and is powered by 110-115 volts with an improved, long-life motor. Food is served at about 150 degrees.

An automatic spoon dispenser is connected electrically to the vending mechanism, dispensing a spoon with each individual can. The new unit can be equipped with either multiple or single pricing mechanism which accepts nickels, dimes and quarters. The VS-7 is of all-steel construction with a silver-gray hammertone baked enamel finish, Fiberglas insulated. It provides a quick and efficient hot food source for personnel or visitors when the kitchen is not in operation. **Fedam Company, River Grove, Ill.**

For more details circle #897 on mailing card.

Jet-Dri Enamel Is Multi-Purpose Finish

Fast drying, excellent resistance and ease of application are some of the features of the new Jet-Dri Multi-Purpose Enamel. The new non-toxic material containing CCR37 dries in 15 minutes when applied by brush, roller or dip and even faster when sprayed on. It gives a baked-enamel-type finish with excellent coverage on wood, metal, masonry, composition materials or plaster. It is resistant to abrasion, oils, acids, alkali, alcohol or hot or cold water.

Jet-Dri is available in 12 attractive colors plus black, clear, white and aluminum, and can be used on walls, floors, cabinets, woodwork, furniture, equipment and other surfaces, indoors or out. **Consolidated Chemical & Paint Mfg. Co., Inc., 456 Driggs Ave., Brooklyn 11, N.Y.**

For more details circle #898 on mailing card.

Plastic "Carbon" Paper Does Not Smudge

"Nu-Kote" is the name given to a new typewriter "carbon" paper employing plastic instead of waxy carbon. A plastic coating containing wet ink is applied to paper stock. The ink is trapped in the coating and released a little at a time when the typewriter keys strike the paper. The ink makes the copy, drying immediately to eliminate smudging. Like a sponge, the plastic coating permits the ink to flow from one area to another, prolonging the usefulness of the paper. Research indicates that only one weight and finish of "Nu-Kote" is needed to meet approximately 90 per cent of all typing copy needs for any number of copies. **Burroughs Corporation, Detroit 32, Mich.**

For more details circle #899 on mailing card.

Thixokon Aqueous Solution Is Urethrographic Medium

Clinical tests are reported to have found Thixokon Sterile Thickened Aqueous Solution to fulfill all major requirements for an ideal urethrographic medium. The solution is completely miscible with water, blood and urine. The radiopaque ingredient, sodium acetrizoate, is safe in case of urethrovascular invasion. Amioca, the thickening agent, is slowly degraded when mixed with body fluids, another safety measure. The viscosity and radiopacity of Thixokon are adjusted to yield highly satisfactory urethrograms in the majority of cases. **Mallinckrodt Chemical Works, 2nd & Mallinckrodt Sts., St. Louis 7, Mo.**

For more details circle #900 on mailing card.

Water Pick-Up Machine Suctions Floors Dry

Sudsy water and dirt are quickly suctioned up from floors with the "SpeeDry" water pick-up machine. Mopping up and wringing out are eliminated with the new machine which picks up dirt along the entire 24-inch width of the intake head. The self-contained unit is easily mobile and operates without hoses, wands or other attachments. The operator merely walks through the wet area with the "SpeeDry," leaving a dry floor behind. The machine works equally well on wood, tile, concrete

or asphalt surfaces and picks up moisture in cracks. Rubber wheels at the ends of the intake head protect walls. **Nobles Enginering & Mfg. Co., 1131 Olympic Blvd., Santa Monica, Calif.**

For more details circle #901 on mailing card.

(Continued on page 168)

Use quality floor waxes containing Du Pont's anti-slip ingredient

LUDOX®

COLLOIDAL SILICA

DU PONT

REG. U. S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING
. . . THROUGH CHEMISTRY

You benefit two ways with floor wax containing "Ludox". First, there's the skid resistance "Ludox" adds. Tiny, transparent spheres of "Ludox" exert a snubbing action with every footstep . . . give sure-footed traction. Second, you get the lasting beauty only a fine wax can give your floors . . . and it's easy to *keep* floors beautiful, because scratches and scuffs can be buffed out, without rewaxing.

Floor waxes containing "Ludox", Du Pont's anti-slip ingredient, give your floors the appearance you want, plus added safety underfoot. Mail coupon below for more information and a list of suppliers for products containing "Ludox". E. I. du Pont de Nemours & Co. (Inc.), Grasselli Chemicals Department, Room N-2533, Wilmington 98, Delaware.

MAIL THIS COUPON TODAY

DOUBLE-ACTION RUG AND UPHOLSTERY SHAMPOOS—A NEW USE FOR LUDOX®

New shampoos containing "Ludox" *clean and treat* rugs against resoiling in just one application. "Ludox" fills microscopic fiber crevices . . . protects surface so dust and dry dirt don't cling. Dirt stays on surface for easy removal.

I'm also interested in:
- ☐ Names of suppliers of anti-slip floor waxes containing "Ludox".
- ☐ More information about double-action rug and upholstery shampoos containing "Ludox".

E. I. du Pont de Nemours & Co. (Inc.)
Grasselli Chemicals Department, Room N-2533MH
Wilmington 98, Delaware

Please send me the free booklet describing the advantages of using floor wax containing "Ludox."

Name_____

Firm_____ Title_____

Address_____

City_____ State_____

WHAT'S NEW

Plastic Salt Dispenser Efficiently Refills Shakers

The problem of keeping salt shakers filled is greatly simplified with the new

Quik-Fill plastic salt dispenser. Offered as a premium to institutional buyers of table salt, the dispenser employs the regular 26-ounce round carton of Diamond Crystal table salt which fits into the hopper. Shakers are held under the spigot for filling and an automatic shut-off valve stops the flow of salt when pressure is released, thus eliminating the mess and waste of spilled salt. Eighteen two-ounce shakers can be filled from one carton in minimum time. The dispenser is molded of high-impact styrene and has a weighted base and flanges which can be bolted down if desired. **Diamond Crystal Salt Co., 916 Riverside St., St. Clair, Mich.**

For more details circle #902 on mailing card.

Full Kitchen Facilities in Compact Dwyer Unit

Full kitchen capacity in only 69 inches of floor space is provided with the new Dwyer Kitchen illustrated. Included in the unit is a seven-cubic foot refrigerator with roll-out shelves and freezer compartment holding nine ice cube trays or 27 packages of frozen food; bake and broil oven; range, and undersink storage. Over 17 square feet of additional storage area is provided in the upper cabinet and the sink is large enough to handle pots and pans of all sizes.

Dwyer compact kitchens are available for gas or electric fuel, standard or recessed

installation, for nurses' homes, staff housing, and other areas where kitchen facilities are desirable but space is limited. Kitchens are finished in life-time vitreous porcelain for long hard usage. **Dwyer Products Corp., Michigan City, Ind.**

For more details circle #903 on mailing card.

(Continued on page 170)

Leading hospitals, large and small, improve record-keeping and meet the Big Cost Challenge of 1958 with Edison Voicewriter dictation.

1:40 A.M.

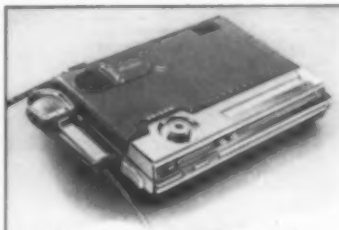
—but Voicewriter's on duty for dictation!

No secretaries around at this time of night . . . but the surgeon has only to pick up that phone to dictate his postoperative report while it's fresh in his mind. The phone is one of the dictating stations in the hospital's Edison Televoice system that helps keep records up to date.

What a blessing to your busy staff! Doctors can keep their reports up to date with half the effort. No waiting for a secretary to take dictation . . . or valuable time spent in writing longhand reports. And Voicewriter is easy for visiting doctors to use, without complicated instructions.

Boosts productivity of records personnel, too! No problems deciphering doctors' written reports as before. No hours consumed taking shorthand dictation, then reading back . . . always with the possibility of error in transcription. With Voicewriter, medical secretaries just transcribe from the Edison Diamond Disc. The doctor's voice comes through clearly, even easier to understand than in direct conversation. It's easy to keep ahead of medical records . . . backlogs are eliminated.

Where should you use Voicewriter? Station this dependable dictating facility at every point where records originate . . . in your surgical suites, doctors' offices, nurses' stations, clinic rooms, pathology labs, radiology. That's how Voicewriter can assure you complete, accurate, up-to-date medical records.



Let us prove your hospital will profit with Voicewriter!

An Edison Voicewriter medical specialist will gladly analyze your needs, without obligation, and help you tailor-make a Voicewriter system to meet your specific requirements. To have him contact you—or for free literature—write Medical Dept. MH7 at the address below.

Edison Voicewriter • a product of Thomas A. Edison Industries

Thomas A. Edison Industries, West Orange, N. J.——In Canada: 32 Front Street W., Toronto, Ontario

McGRAW EDISON

WHAT'S NEW

Automatic Change Dispenser Eliminates Errors

Speed and accuracy in making change in cafeterias and other operations can be assured with the new change-dispensing cash register introduced by National Cash Register Company. The correct amount of change due is calculated and dispensed automatically when the sale is rung up and the bill received is recorded by the cashier. The correct change is released automatically to the customer through the automatic coin dispenser which may be located away from the register for convenience. Paper bills, of course, will be handled by the cashier but the correct number is recorded on the machine, again assuring accuracy. A warning buzzer indicates when the supply of coins is running low and the dispenser will not work when any coin channel is empty. **National Cash Register Co., Dayton 9, Ohio.**

For more details circle #904 on mailing card.

"Dip and Read" Test for Proteinuria and Glycosuria

Uristix Reagent Strips is the name given to the new "Dip and Read" combination urine test for proteinuria and glycosuria. The test portion of Uristix, impregnated with reagents that change color with positive tests, has a barrier separating the test for proteinuria from that for glycosuria so that color changes are easily read when each test is compared to the color guide printed on the bottle label. Uritistix is supplied in bottles of 125 reagent strips. **Ames Company, Inc., Elkhart, Ind.**

For more details circle #905 on mailing card.

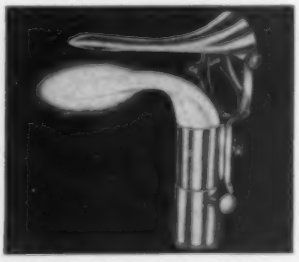
Nine Ready-Mixed Colors Added to Paint Line

Barreled Sunlight Odor-Free Interior Alkyd and Outside Paint is now available in nine new ready-mixed colors. Selected after extensive field research, the new colors include six clear pastels for interior walls, ceilings and woodwork and three body colors for outside siding or trim. The additions to the line now make available a total of 18 Odor-Free matching colors, plus white, in Interior Alkyd Flat and Semi-Gloss paint, and 16 colors in exterior paints. **Barreled Sunlight Paint Co., 12 Dudley St., Providence 1, R.I.**

For more details circle #906 on mailing card.

Non-Glare Shadow-Free Light in Coldlite Instruments

A new illuminating principle for diagnostic instruments is introduced in Coldlite Instruments. The light source is installed in the instrument handle and produces a concentrated, non-glare light that is completely shadow-free. The light is transmitted to the deep area of examination without any obstructing light carrier. The illuminating parts of Coldlite instruments are carved from solid blocks of plastic, making them unbreakable in normal use.



They may be sterilized by boiling and operate from a standard 6-volt transformer or dry battery. Instruments in the new line include various types of vaginal specula, sigmoidoscopes and anascopes. **E. Miltenberg, Inc., 43 Great Jones St., New York 12.**

For more details circle #907 on mailing card.

(Continued on page 172)

with Carrier the ice is right...and capacity's certified in writing

Carrier offers you a choice of 15 ice machines, so you get *just* the ice you need. It's the most complete line there is. That's why you'll never hear a Carrier man ask, "But won't this ice do just as well?"

Carrier alone gives you ice production with Certified Capacity in writing. And this production figure is determined by air and water temperatures where you live, not by hypothetical laboratory conditions. That's why you'll never hear a Carrier man say that ice capacity is "up to" so many pounds a day.

Your Carrier dealer has a lot of interesting things to point out—like savings of 80% or more on ice bills. Phone him today. He's listed in the Classified Directory under Ice Making Equipment. Or write to Carrier Corporation, Department 123, Carrier Parkway, Syracuse 1, N. Y.

ICEMAKERS for cubes or crushed | CHIPMASTERS for chips | FLAKEMASTERS for flakes

Carrier AIR CONDITIONING · REFRIGERATION

WHAT'S NEW

Heinz Instant Potato Saves Preparation Time

Time saving and convenience are added to fine flavor, appearance and economy in the new Heinz Instant Potato. Instant potatoes, prepared in small or large batches, permit serving of a Number 10 ice cream disher of fluffy mashed potatoes at a cost less than that of the labor saved. Any quantity can be quickly and easily prepared and portion control is another advantage.

Only selected Idaho Burbank Russet potatoes are used in making Heinz Instant Potato, assuring high quality with constant price and convenience. In the processing, vitamin and mineral content are protected to assure good texture and flavor. Heinz Instant Potato does not lose its quality in storage, requires minimum storage space, and since it can be treated as a staple, it requires less critical handling. Many variations of mashed potatoes can be served, such as the potato croquettes pictured. **H. J. Heinz Co., Box 57, Pittsburgh 30, Pa.**

For more details circle #908 on mailing card.

Solid Plastic Folding Arm on Hampden Tablet-Arm Chair

The Hampden tablet-arm folding chair is now available with solid plastic tablet-arm. The new solid plastic arm conforms to specifications for a melamine resin plastic surface on each side, on an extremely dense and homogeneous core, simultaneously welded together. The top is birch grain design and the chair is of sturdy tubular-steel construction with contoured steel seat and back.

The strong, attractive chair is suitable for use in classrooms, lecture halls, music rooms and wherever a sturdy, folding armchair is needed. The Hampden tablet-arm chair is now available in any combination of all solid plastic or 5-ply hardwood tablet

arm and steel, upholstered or blonde plywood seat. All metal parts are rustproofed and the automobile finish in beige or gray does not scuff or chip. Replaceable rubber-tipped feet protect floors. **Hampden Specialty Products, Inc., Easthampton, Mass.**

For more details circle #909 on mailing card.

Three Conductive Products for Shoes Worn in Surgery

Three new items to make shoes safely conductive are offered by O-R Products Company. The O-R Deluxe Conducto-Sole gives maximum surface contact for safe conductivity and will wear from ten to twelve weeks. It is available in two sizes, for men and women. Made of heavy duty conductive rubber with snap-fasteners, it is bonded to the sole of the shoe with O-R cement.

The Plantar Conducto-Heel provides a permanent conductive element. The heel strip is composed of heavy duty conductive rubber with snap-fasteners for easy replacement. It is attached to the outside of the heel. An inexpensive Disposable Conductive Strip No. 11 is also available for emergency use. It is made of a special lamination of Myal Conductive Material to be adhered to the heel portion of the shoe and is easily removed when no longer needed. **O-R Products Co., 68 Elmwood St., Newton 58, Mass.**

For more details circle #910 on mailing card.

(Continued on page 173)

WHAT'S NEW

Whole, Boned Turkey Is Pre-Cooked for Portion Serving

Light and dark meat are combined in the boneless roll of pure turkey meat offered in the new Armour Star Turkey Roll. The roll can be sliced to precise portion sizes for sandwiches, plate dinners, salads or casseroles. It speeds preparation of turkey dishes while offering full portion and cost control.

Armour Star Turkey Roll consists of an eight to ten pound roll of 60 per cent white and 40 per cent dark meat completely sealed in a moisture-proof casing and hard frozen to protect quality and flavor until used. There is no shrinkage or waste, all natural meat juices are retained, and the Turkey Roll requires minimum storage space. **Armour & Co., Poultry Dept., Chicago 9.**

For more details circle #911 on mailing card.

Roof Ventilators of Aluminum or Steel

Spun aluminum housings are used on the smaller models of the new line of centrifugal roof ventilators for exhausting air from institutions. The larger models are built of steel but all have a low silhouette design and are offered in 10 direct-drive and 11 belt-drive sizes. Air volume in the various models ranges from 180 to 6956 cubic feet per minute. **The Trane Company, La Crosse, Wis.**

For more details circle #912 on mailing card.

Colorful Plate Covers in Styrene Plastic

Food is kept warm longer with the new line of styrene co-polymer dish covers recently introduced. Available in three sizes, the plastic covers are readily stacked and cause minimum noise in handling. They require no preheating, yet hold heat in food for long periods. They are light,

strong, durable, chemical resistant and clean easily. Available in gray, coral, turquoise, buff and a crackled finish, the dish covers add a cheerful note to patient trays. **Chicago Molded Products Corp., 1020 N. Kolmar Ave., Chicago 51.**

For more details circle #913 on mailing card.

Log Cabin Syrup in Institutional Pack

The well-known blend of sugar and maple syrups known as Log Cabin Syrup, is now available packed for quantity service. One gallon cans, four to a case, are now available to food service departments. Distribution is through warehouses located throughout the United States. Log Cabin Syrup, in addition to its use on hot cakes, waffles and French toast, is also suggested as a pour-on for biscuits and as an ice cream topping. It can also be used to baste and glaze meats, as a vegetable glaze and to sweeten fruit. **General Foods, White Plains, N.Y.**

For more details circle #914 on mailing card.

AC Presswitch Operates With Slight Touch

A slight pressure of the fingers or nudge of the elbow is sufficient to turn the new Presswitch on or off. The new alternating current switch has a smoothly tapered nylon button in either Ivorine or brown finish. Particularly well adapted to fluorescent lighting installations in hospitals, the new Presswitch simplifies light control. It is available in single pole, double pole, three-way and four-way and operates in any position. No special wiring is required as the switch fits all standard wall boxes and utilizes standard wall plates. **Harvey Hubbell, Inc., State St., Bridgeport, Conn.**

For more details circle #915 on mailing card.

(Continued on page 174)

McBee Handiprinter Is Portable Duplicator

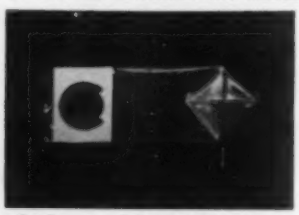
Reproduction of fixed information such as names and addresses is facilitated with

the new McBee Handiprinter. The portable, spirit-type duplicator employs an aperture Keysort ledger card as the duplicating master. It speeds up heading of records, addressing envelopes and other work where simple information must be reproduced, while eliminating errors in spelling and other information. **Royal McBee Corp., Port Chester, N.Y.**

For more details circle #916 on mailing card.

Disposable Unit for Infant Urine Collection

The PUC-10-S is a sterile polyethylene bag for use on both male and female infants for the collection of body fluids or sterile urine specimens. The disposable bag is ready for use by merely removing the cover from the pressure sensitive tape and affixing to the infant. When filled and removed, the folded top of the bag becomes self-sealing, providing a leakproof container for transportation of the specimen. The completely disposable unit can also be used to determine the amount of



body fluids passed by infants, to prevent bed wetting and to eliminate diaper rash. **Sterilon Corp., 500 Northland Ave., Buffalo 11, N.Y.**

For more details circle #917 on mailing card.

Vinyl Plastic Used for Floor Mats

Traffic King floor mats are now fabricated in vinyl plastic for long life and nonslip footing wet or dry. Segments of the mat are woven on rust-resistant galvanized steel spring wire with openings too small to catch narrow shoe heels. The new mats are lighter in weight and easier to handle than earlier models. They have increased cushioning effect and give longer wear. Dirt stays on the surface of the plastic mats, making them easy to clean. The Traffic King is designed to go under all doors with ¼ inch or more clearance. It is available in 15 fade-resistant colors in a wide variety of patterns. **American Mat Corp., 1717 Adams St., Toledo 2, Ohio.**

For more details circle #918 on mailing card.

(Continued on page 176)

WHAT'S NEW

Two-Way Truck in Jan-i-San Cart

The 1958 model of the Jan-i-San Collector Cart is a two-way truck. Serving as a collector cart with the bag attached, the Jan-i-San is a platform truck when the canvas bag is removed. The new offset-type handle assures more comfortable steering and the 10-inch rubber-tired ball bearing wheels facilitate rolling over curbs, down steps and on any type of floor surface. The cart is available with a choice of several bag types and sizes for various needs. **The Paul O Young Co., Line Lexington, Pa.**

For more details circle #919 on mailing card.

Slide Screening Test for Rheumatoid Arthritis

RA-Test is a slide modification of the latex fixation test, used to detect the presence of rheumatoid factor in the serum of arthritis patients. The rapid slide screening test is performed by a simple procedure. It is marketed as a kit containing sufficient material for at least 100 tests. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #920 on mailing card.

Bongort Stoma Bag Saves Dressing Bulk and Costs

The Bongort "Sealtite" Stoma Bag has a special adhesive material which is punched with a hole to fit stoma or fistula. It forms a sealed and leakproof union of the bag and the skin to handle post-operative drainage. The open bottom of the bag, for ease of emptying, is closed with a tie or rubber band and can be re-closed after cleaning. The bag is designed to be applied after surgery to handle all types of drainage and eliminates the need for bulky dressings. The bag is made of plastic film and is available in various styles, including bags with tape and belt for ambulatory patients. **United Surgical Supplies Co., Inc., 134 Midland Ave., Port Chester, N.Y.**

For more details circle #921 on mailing card.

Economy Folding Chair Has Tubular Steel Frame

Minimum price is combined with maximum comfort and strength in the new Samsonite Economy Folding Chair. The all steel tubular frame finished in black or bronze has a back support for comfort and plastic "feet" to protect floors. The

padded seat is covered with washable vinyl in three colors. **Shwayder Bros., Inc., 4270 High St., Detroit 29, Mich.**

For more details circle #922 on mailing card.

Rectangular Waste Basket Has Rounded Corners

Practically indestructible vulcanized fiber is used to form the new round-cornered rectangular Fiberok waste receptacle. It is reinforced with a rustproof galvannealed steel channel at the top and bottom, has two metal reinforced hand holes at the sides, and a recessed bottom to facilitate handling and emptying. The new waste basket is available in two standard sizes. **Federal Fibre Corp., 37-10 Tenth St., Long Island City 1, N.Y.**

For more details circle #923 on mailing card.

(Continued on page 178)

WHAT'S NEW

Storage on Wheels Increases File Capacity

The Rol-Rak is a mechanical development permitting the use of all available space for filing in a storage area. Aisles between files are not necessary when the Rol-Rak is used since filled file shelves roll aside for access to other filled shelves.

Rol-Rak tracks rise one-half inch above the floor. Placed in parallel rows, standard-type files, racks or shelves are mounted on them in solid formation, with just enough space allowed to roll the units aside for access to any unit in rows behind.

The wheeled base units are adjustable in all directions to fit cabinet or rack units ranging from 24 to 48 inches in width. Each standard unit has a load capacity of one and one-half tons. **Mobile Racks, Inc., 369 Lexington Ave., New York 17.**

For more details circle #924 on mailing card.

Seven Dirt-Resistant Waxes Added to Multi-Clean Line

Seven new waxes which resist soiling because they are completely free from tacking are now available in the Multi-Clean line. Floors treated with the new waxes are said to require less frequent cleaning and when they do become soiled, the dirt is easily removed. The waxes are available in regular and anti-slip formulations and in Deep Glow Floor Wax which is a budget priced, water resistant product. **Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn.**

For more details circle #925 on mailing card.

Improved Service Cart Has Multiple Uses

Improvements in style and size are incorporated into the new Lyon Service Cart. The larger cart, 36 by 24 by 32 inches in size, is a versatile unit for use in cafeterias and other food service areas, stock rooms, and as a portable stand for instruments. Pan-type trays three inches deep adapt to many uses. Five-inch casters ensure easy rolling. The carts are finished in green baked-on enamel. **Lyon Metal Products, Incorporated, Aurora, Ill.**

For more details circle #926 on mailing card.

Three Low Priced Duplicators With Quality Features

Three new duplicators recently introduced by Ditto are described as having high quality features at low prices. They have modern styling, lower and wider than previous models, with quiet operation. Model D-30, hand operated, and Model D-31, electrically operated, give positive registration of master to copy paper through a knurled wheel in the drum, and copies automatically fall into stacked alignment in the receiving tray. These models are equipped with liquid-control dials for maximum fluid economy, and both liquid and pressure levers are of the latch type for quick accurate positioning without slipping.

The machines have a top speed of two copies per second and can handle paper from 13 pounds to card stock without adjustment and any sized sheet from three by five to nine by fourteen inches. The third new model is the Ditto D-20, designed for budget buying, yet providing high quality copies. **Ditto, Incorporated, 6800 McCormick Rd., Chicago 45.**

For more details circle #927 on mailing card.

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WHAT'S NEW

Pharmaceuticals

Visine Eye Drops

A sterile, stable, buffered solution of tetrahydrozoline, Visine Eye Drops is an effective ophthalmic decongestant. It is indicated for symptomatic relief of eye inflammations caused by allergies, irritants, strain and non-bacterial conjunctivitis of various types and supplies prompt and prolonged action. **Pfizer Laboratories, Div. of Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #928 on mailing card.

Sterile Solution Heparin Sodium

Heparin Sodium, Abbott, is a highly purified heparin derived from animal tissue and standardized for use as an anticoagulant. Widely used to prevent the occurrence or extension of thrombosis or embolism, Heparin has also been employed as an anticoagulant in blood transfusion and in certain surgical and laboratory procedures. Sterile Solution Heparin Sodium, Abbott, is supplied in rubber-stoppered vials and in ampoules for intravenous infusion or injection. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #929 on mailing card.

Kenacort

Kenacort is a new derivative of prednisolone useful in corticosteroid therapy, especially because it does not cause sodium and water retention in the usual dosage. Kenacort is devoid of psychic stimulation and produces minimum gastric upset. Clinical tests indicate Kenacort as effective in various allergic, inflammatory and dermatological conditions. It is supplied in one mg. tablets in bottles of 50 and 500, and in four mg. strength in bottles of 30 and 100. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #930 on mailing card.

Meticortelone Soluble

Meticortelone Soluble is described as the first prednisolone corticosteroid preparation for intravenous use in humanbeings. It is indicated in cases of stress crisis and offers a systemic prednisolone in a rapidly effective intravenous form. It is a sterile powder form of prednisolone which is stable, does not carry a potency expiration date and is compatible with normal saline or dextrose solution, plasma, whole blood and intravenous anesthetic. **Schering Corp., 96 Orange St., Bloomfield, N.J.**

For more details circle #931 on mailing card.

Dulcolax

Dulcolax is a new synthetic compound for safe, effective relief in all types of constipation. It is virtually insoluble in intestinal juices and gentle and non-toxic in action. It acts directly on the colonic mucosa and produces no systemic effects. Dulcolax produces normal contractions of the entire colon, achieving complete evacuation. Its gentle action permits use with children, aged, pregnant or nursing women and debilitated patients. It is supplied as both tablets and suppositories. **Geigy Pharmaceuticals, Ardsley, N.Y.**

For more details circle #932 on mailing card.

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WHAT'S NEW

Literature and Services

• **"Kill Deadly 'Golden' Staphylococci in Just Minutes"** is the subject of a special **Hospital Bulletin** released by Associated Just Distributors, Inc., 702 S. Wolfe St., Baltimore 31, Md. How "Just" Cleaner-Disinfectant totally destroys antibiotic-resistant staphylococci and other similar pathogens is discussed, with information on the results of bacteriological tests.

For more details circle #933 on mailing card.

• Filmstrip is used to record and preserve the most outstanding scientific exhibits at major medical conventions. Designed as a service for medical communication and medical education, the **"Exhibits-On-Film, a Library of Scientific Exhibits,"** is supported by Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 1, Wis., pharmaceutical manufacturer. The filmstrips will be available through executive secretaries of county medical societies and through medical college libraries.

For more details circle #934 on mailing card.

• Outstanding examples of bronze, nickel-silver and aluminum metalcraft artwork are shown in a new 36-page catalog, **"Fine Sculptured Plaques,"** published by Meierjohan-Wengler Co., 1102 W. Ninth St., Cincinnati 3, Ohio. **Folder W** is a comprehensive catalog of distinctive memorials and tablets, plaques, door, desk and donor plates, tablets, emblems, insignia and honor rolls available from this firm of metalcraftsmen.

For more details circle #935 on mailing card.

• A series of five folders, each containing 12 quantity **Kitchen Tested Recipes** "for menu variety and money-saving quality," is offered by Custom Food Products, Inc., 701 N. Western Ave., Chicago 12.

For more details circle #936 on mailing card.

• **Catalog No. 18** covers the line of oxygen Therapy equipment available from Hudson Oxygen Therapy Sales Co., 2801 Hyperion Ave., Los Angeles 27, Calif. In addition to the regular line, the catalog gives data on a Hi Humidity Croup Tent and a Plastic Oxygen Mask as well as other items new to the line.

For more details circle #937 on mailing card.

Suppliers' News

General Bandages, Inc., manufacturer of self-adhesive Gauztex bandages, announces removal from its offices at **531 Plymouth Court, Chicago**, to its new plant at **8300 Lehigh Ave., Morton Grove, Ill.**

Grant Pulley & Hardware Corp., High St., West Nyack, N.Y., manufacturer of hospital cubicle hardware, announces the formation of the **Hospital Cubicle Division** headed by **Mr. Herbert F. Cupo.**

Handy & Harman, 82 Fulton St., New York 38, refiners and processors of silver, gold and other precious metals and alloys, announces a nation-wide service for salvaging the silver from used or outdated x-ray film. Two options for handling the film are available to hospitals and radiologists.

Massillon Rubber Co., Massillon, Ohio, announces a change of name. All latex surgeons' gloves manufactured by the company will be known as **Matex gloves** in future, designated **Matex white or Matex brown.** The name **Massillon Latex** for brown gloves will be discontinued.

National Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago, 11, manufacturer of medical gases and medical gas equipment, announces its appointment as exclusive distributor of the **Ventalung.** Developed by the **J. J. Monaghan Co., Inc., Denver, Colo.**, the Ventalung is a demand-type intermittent positive-pressure breathing instrument cycled to the patient's own respiration.

Shampaine Industries, 1920 S. Jefferson, St. Louis 4, Mo., announces formation of a new, nationwide **field service organization** with divisional headquarters in Los Angeles, Calif., St. Louis, Mo. and New Rochelle, N.Y. The new organization consolidates the maintenance services of the nine member companies of Shampaine Industries.

Simoniz Company, 2100 Indiana Ave., Chicago 16, manufacturer of maintenance products, announces the reorganization of its **Commercial Products Division** as an independent marketing unit within the organizational structure of the company, with **H. C. Rains** as manager of the division.

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The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.

When, in either an advertisement or "What's New" you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.

Detach and mail — no postage required.

July, 1958 (b)

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SEC. 34.9 P. L. & R.
CHICAGO, ILL.

BUSINESS REPLY CARD
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3 CENT POSTAGE WILL BE PAID BY

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(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File—35th Edition.

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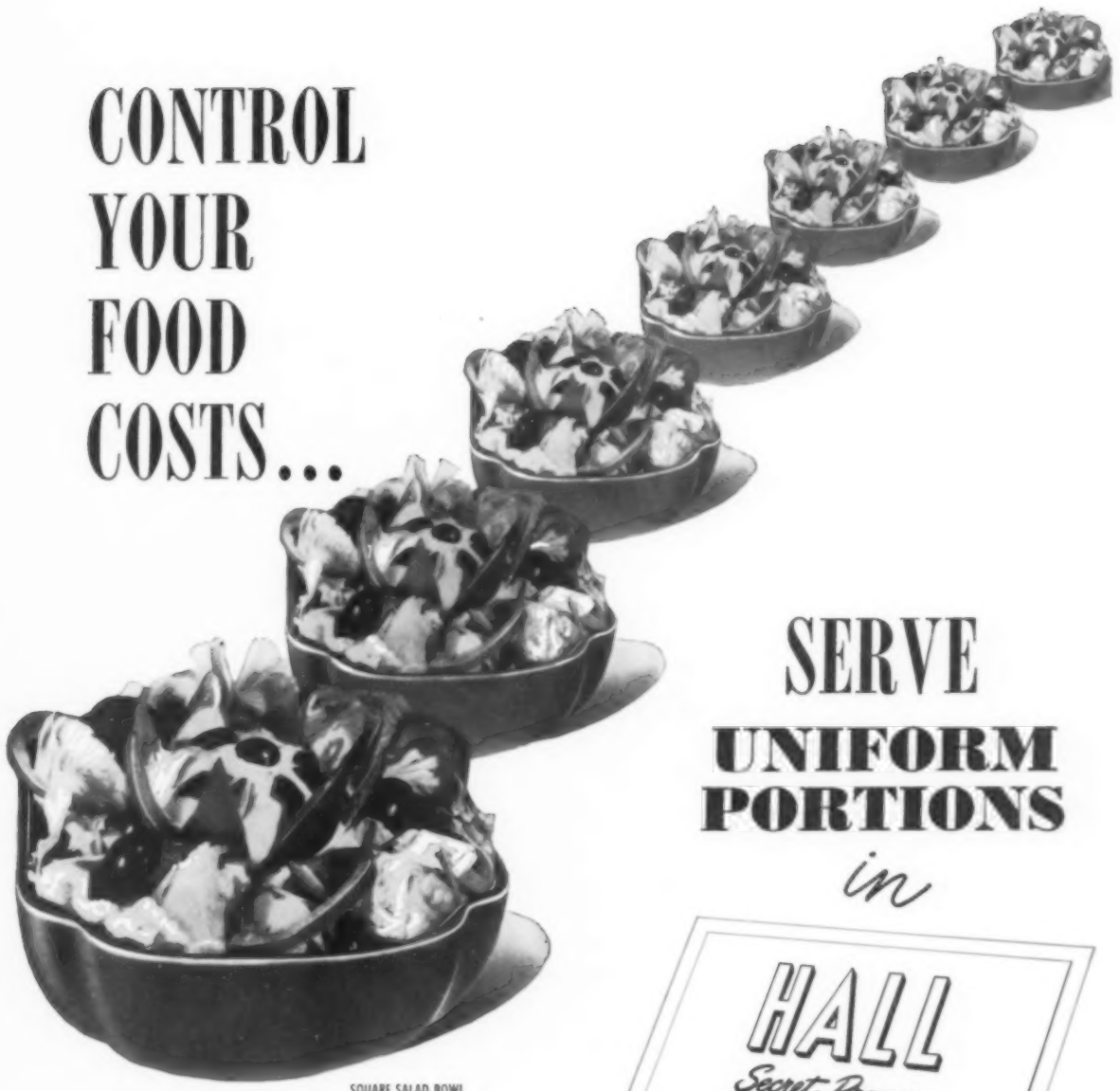

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HALL
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FIREPROOF CHINA
AVAILABLE IN 26 BEAUTIFUL COLORS

Hall Salad Dishes, like Hall baking dishes, can be used for automatic control of portions. The capacity of the ware assures uniform servings. Hall Salads are impervious to acids in food and condiments; extremely resistant to scratching or marring; will not pit or corrode—look like new after long service. Write for Bulletin SM-1.

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The World's Largest Manufacturer of Fireproof Cooking China

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TO THE SECRET PROCESS
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Secret Process **HALL CHINA** plated with lustrous nickel-chrome by a secret process.
Write for Bulletin MC-65

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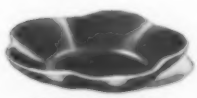
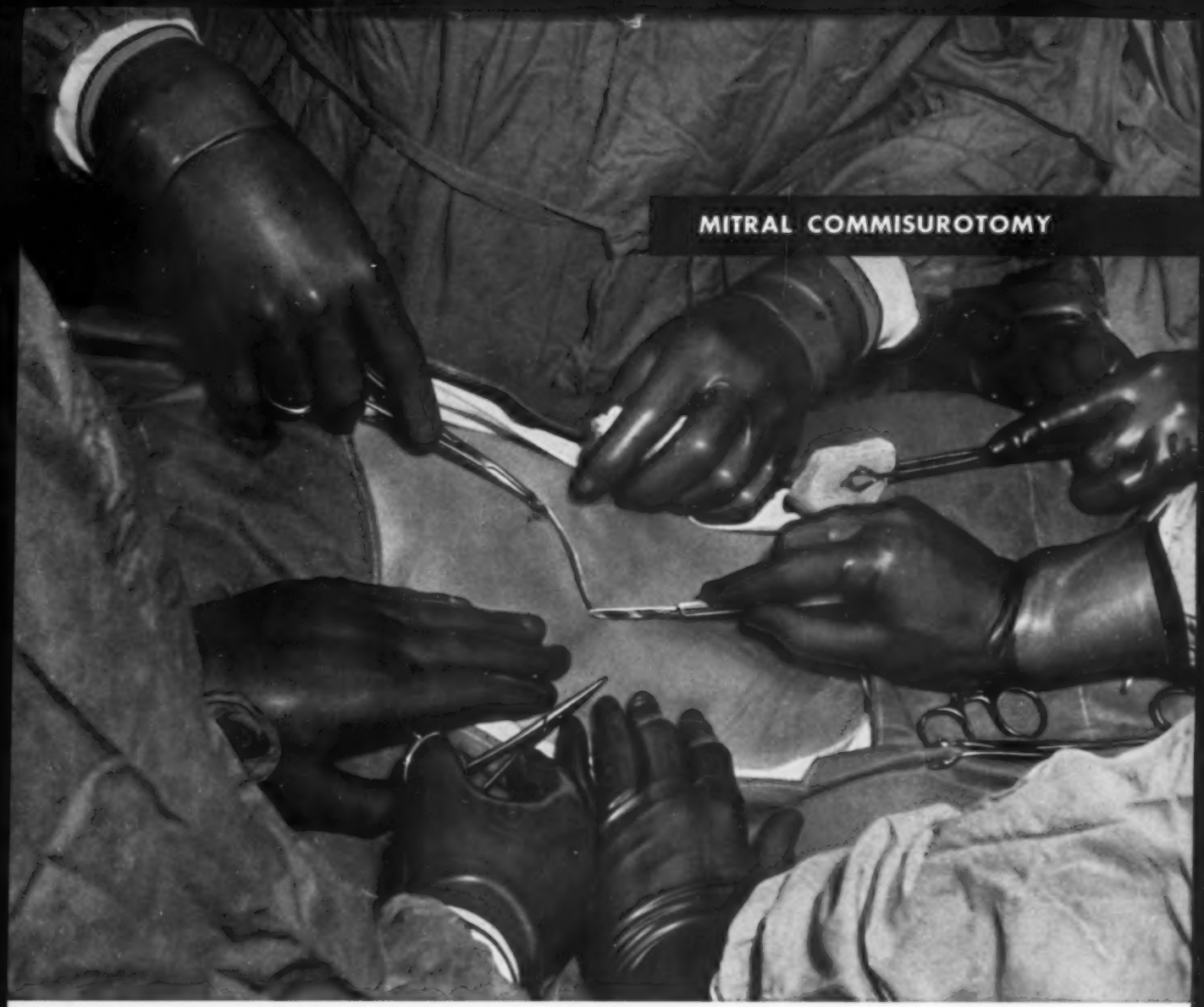
FOOTED SALAD BOWL

FISH SALAD BOWL

SALAD



SCALLOPED SALAD BOWL



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